

OFFICE OF
PROGRAM EVALUATION

February 18, 1976

The Honorable Members of
The Board of Supervisors
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Gentlemen:

Subject: Drug Program Evaluation

This document contains the results of our evaluation of the County Drug Abuse Program. The Report is divided into three major parts:

1. An analysis of the Drug Delivery System with emphasis on planning, support services, and the Federal - State - local interface.
2. An assessment of the administrative efficiency and impact of methadone programs.
3. An impact analysis of therapeutic communities.

Our drug system encompasses over four million dollars, several funding sources, numerous County departments, and a variety of community-based programs. This complexity creates the system's most crucial requirement, that is, the need to do comprehensive planning and priority setting that includes all the organizations involved with drug services. The theme of developing a sound rationale for funding decisions runs throughout this evaluation.

Traditionally, drug treatment programs have had difficulty in creating a drug-free environment for prolonged periods. Also, a consistent level of quality and administration is difficult to achieve because of non-controllable social, cultural, and economic factors affecting the client-program interface. This produces an apparent low cost effectiveness. A great deal of time needs to be



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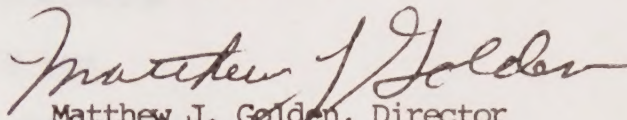
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Very truly yours,


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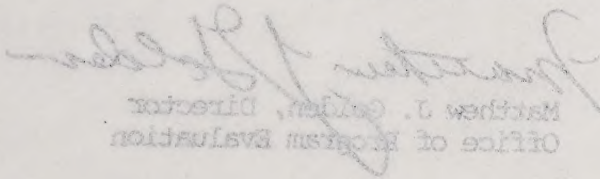
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AN EVALUATION
OF THE
COUNTY DRUG PROGRAM

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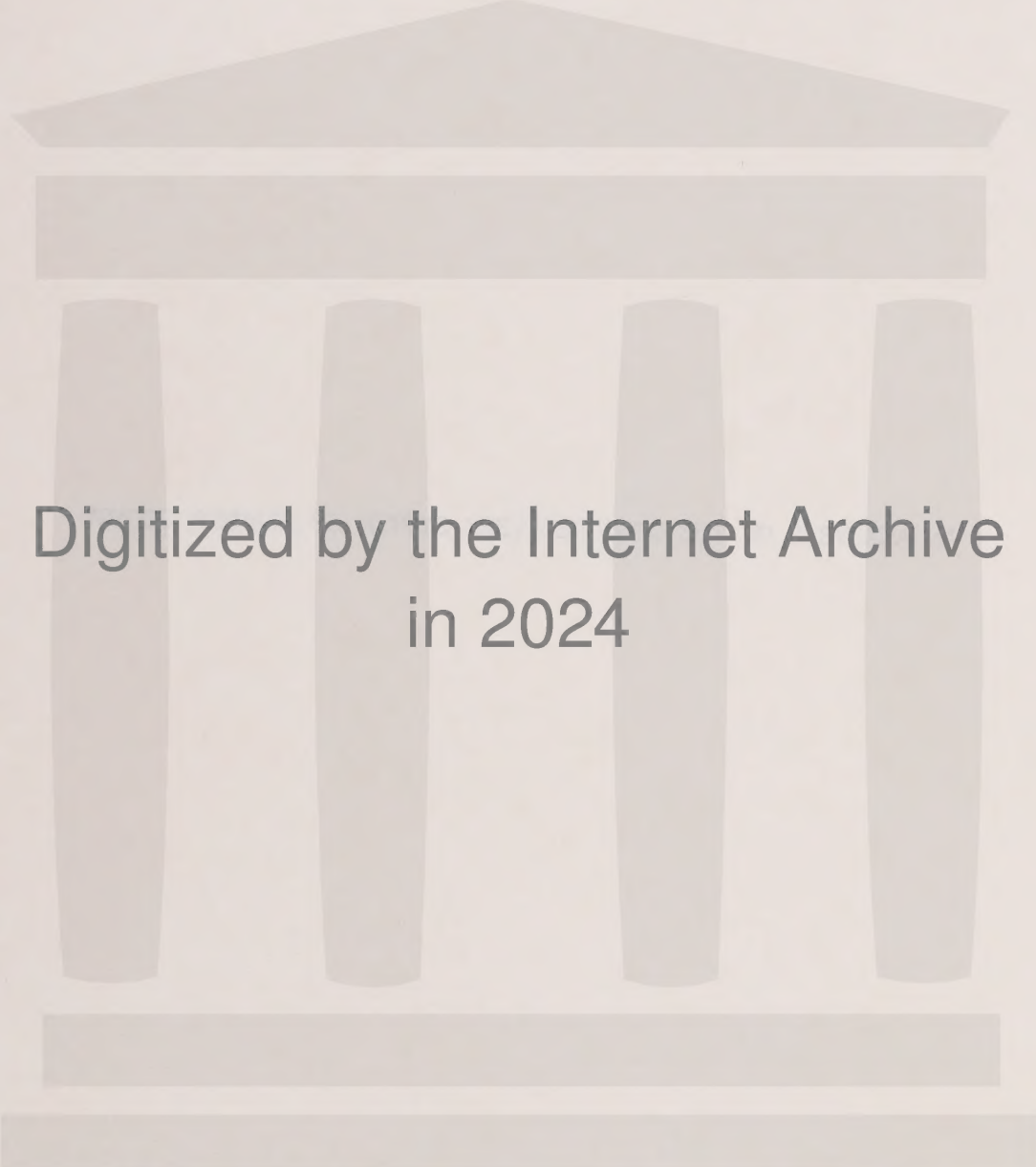
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AN ANALYSIS OF THE DRUG DELIVERY SYSTEM OF ALAMEDA COUNTY



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AN ANALYSIS OF THE COUNTY DRUG DELIVERY SYSTEM

Introduction

This section of our evaluation assesses the role, basic mission, relationships and planning and management effectiveness of those organizations contributing to the delivery of drug services. The interface between client and service provider is the end result of a complex series of events involving numerous individuals, organizations, and agencies. These encompass multiple levels of government and cross agency and department lines in the County. Funding comes from multiple sources with varying levels of approval, inconsistent rationale, and with differing philosophies and priorities. We attempt to define this complex process as a single delivery system and to present some insight into major problems and constraints. Although this is an evaluation of County drug programs one must recognize interdependence of each level of government in deciding priorities. The drug program is in many ways a classic example of the Federal-State-local interface; theoretically operating with similar goals and objectives and within the bounds of a defined system with mutually supportive procedures but in fact possessing many divergent objectives and communication, planning, and operational problems. Our analysis and recommendations with respect to the County are presented while understanding the County as only one component of a broader system.

Background

The County drug program and its coordinative focal point the Office of Drug and Alcohol Abuse are comparatively young and are still changing as the County attempts to provide effective drug abuse services. It is useful to briefly discuss the program's evolution to place this section's contents in proper perspective. Before December, 1973, the drug program was part of the Mental Health Service. With July 1, 1974, funding for Drugs and Alcohol was provided through the Short-Doyle mechanism with the monies clearly identified for Alcohol and Drug Abuse Programs. This basic move at the Federal and State level contributed to a series of actions within the Health Care Agency which produced the present framework of the Office of Alcohol and Drug Abuse. These were:

1. The proposal to create an assistant agency director for Alcohol and Drug Abuse to be responsible for providing technical expertise to County-operated and contract programs, negotiating contracts, monitoring performance, evaluating the effectiveness of various program components, and finally to develop new approaches to handling problems and identifying additional funds.
2. The new position would be supported by a small staff doing various technical assistance - planning tasks.
3. The small central staff would not have "line" responsibility for operating programs and the relationship between the central office and programs would be contractual in nature.

4. The regional structures of Health Care with respect to Drug and Alcohol were maintained and OADA became a fact within that structure.
5. A full budget and staffing plan was developed, presented and adopted and under the guidance of the assistant agency director described the office's role as:
 - Planning County-wide programs and setting standards for treatment, rehabilitation, and control of alcohol and drug abuse.
 - Organizing and coordinating service delivery systems including community-based programs.
 - Processing and allocating funds and negotiating contracts.
 - Monitoring and evaluation of programs.
 - Conducting research studies and developing innovative programs.
 - Conducting prevention and education programs.

The office operated under this general assignment until the fall of 1975 when it again reorganized to meet new administrative requirements. This restructuring was designed to:

- Create compatibility with a general Health Care Agency reorganization.
- Deal with certain problems in delivering services from a regional concept.
- Providing consistent supervision and control over County-operated drug and alcohol programs.

Implementation of the reorganization was underway during the conduct of this evaluation. The full effect of the reorganization cannot be determined until implementation is completed and the office's internal procedures and personnel become accustomed to working with the new framework. We were aware of the reorganization during our analysis, but do not believe it has achieved an adequate level of implementation to affect our conclusions and recommendations. Also, our evaluation addresses issues of decision making, role of the OADA, planning and priority setting, communications, supportive services, and funding mechanisms. These issues tend to be present regardless of organizational considerations.

Methodology

From October 13, 1975, to December 3, 1975, members of the evaluation team gathered data by interviewing relevant persons, reviewing documents, attending meetings, and soliciting responses to written materials. The report discusses critical service delivery and support issues that were identified by our evaluation team, community program directors, members of the Office of Alcohol and Drug Abuse, and an Ad Hoc Advisory Committee. We reviewed documents such as the State Drug Plan, the County Plan for 1975-76, previous evaluations and monitoring reports, and various interdepartmental communications. Meetings of the Technical Advisory Committee on Drug Abuse (TACDA), the Health Care - Probation Coordinating Committee, and other ongoing committees were attended by at least one team member. Interviews were held with a cross section of people operating drug programs. In addition, a questionnaire (see appendix) was developed and distributed to all program directors asking for their opinions on issues raised in our overview. Persons completing the questionnaires were assured absolute confidentiality, and due to the narrative style of the responses, it is difficult to provide tabulated data on their content without revealing their identity. 12 of the 26 questionnaires were returned and supplemented by interviews with several additional program directors. There is no way of knowing whether all the program directors who did not respond reflected similar attitudes.

Our evaluation procedures included a reaction phase wherein "11 members of our Ad Hoc Advisory Committee and the methodology program directors examined our final report and submitted written commentary. Some changes were made as a result and Agency and contractor commentary is included in a separate section of this report."

In Perspective

It is important to define the limits of the Drug Delivery System to avoid evaluating the entire State and Federal structure. For our purposes, the "system" consists of a number of major components. These are:

1. Policy Formulation

The purpose of evaluating this issue is to determine how policy is formulated in the County and at what departmental level policy decisions are made with respect to drug programs.

2. Planning and Priority Setting

Here we will look at the importance of planning and priority setting and analyze their utilization in making program decisions, the manner in which community needs are assessed, and how this gets translated into action.

3. Funding Mechanisms

It is essential to understand how State, Federal, and County monies flow to the drug program. This has particular importance when it comes from multiple sources.

4. Advisory Structures

Advisory committees and coordinating councils play an important role in assisting and advising operating departments and programs on matters involving the drug delivery system. We will study the most important one, the Technical Advisory Committee on Drug Abuse (TACDA).

5. Supportive Services

We will examine the County's role in providing support services to the programs; how well this role is carried out and what areas need improvement. Also the availability and utilization of outside resources will be examined.

6. Criminal Justice and The Drug Delivery System

Judges from criminal justice refer cases to drug treatment programs. Their attitudes toward treatment and knowledge of programs materially affect who gets referred and where they go. We will describe the Court's role in the County's drug program.

7. Office of Alcohol and Drug Abuse

This key unit in the drug system will be examined on its role and contribution in light of existing capacities and potential alternatives.

8. Drug Abuse Delivery System - The State of California

A brief description of the State's drug abuse delivery system will be presented. Recent State trends in drug abuse program planning will be pointed out, and recommendations will be made for improving the County's relationship with the existing State system.

The interaction among these elements is the subject of this section. We will analyze the quality of system administration and indicate improvements. Key organizational units in making this system work are the County departments, Board and CAO, contractual organizations, advisory structures and State and Federal Agencies. It is important that these "institutional entities" work hard to communicate and coordinate effectively. Communications and Evaluation will also be discussed not as integral parts of the system but as activities which are critical to operations and to periodically assessing effectiveness.

I. POLICY FORMULATION

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Policy regarding drug programs is set at all levels of government. This causes all organizations and people involved in service delivery to operate with a high degree of confusion and within conflicting policy frameworks. More serious is its effect on the direction of programs at the community level and the ability of the County to produce relevant (to need) plans and program priorities. The crisis orientation observed in the OADA and gaps in the County Plan (see next section) can be somewhat attributed to present ambivalence in program policy, purpose, and direction.

At the State and Federal level policy seems to change with each election. Recently, the State through S.O.N.D.A. pronounced inconsistent policies pertaining to the use of N.I.D.A. "409" funds, changing the emphasis from new or expanded "priority" programs to innovative approaches which replace existing treatment plans.

The County needs to establish a formal policy for Drug programs. This should occur regardless of the domination of the State. At a minimum, it will meet the need for improved communication and coordination at the County level. Several people interviewed commented that local "policy" was often arrived at mysteriously and communicated by rumors. Without clearly defined policies that spell out the County's goals and objectives that define a commitment and approach to specific treatment philosophies, it is impossible to design relevant programs and establish priorities.

The County Administrator's Office plays a key role in promoting policy guidelines by the Board and in insuring policy implementation by County departments. One recent change in the CAO that should further facilitate consistent policy application among departments is the creation of the position of Program Coordinator. This position is responsible for all aspects of agency and department level program coordination, and can add the same coordination within the CAO's office. However, true operational effectiveness can only be achieved after establishing basic policy for the County's drug program.

II. DRUG ABUSE DELIVERY SYSTEM - THE STATE OF CALIFORNIA

The role of the State in the delivery of drug services is one of the first components to be discussed. This is appropriate because of the dominant influence decisions at this level have on local drug planning and administration.

Description of the System

The overall responsibility for Drug Abuse prevention and treatment in California rests with the State Office of Narcotics and Drug Abuse (SONDA). This is a coordinating unit which is located in the Health and Welfare Agency. It was created in 1970 by Division 108 of the Health and Safety Code (Amended in 1972 by SB 714). Mandated duties of the office include:

1. Coordinate State and local narcotics and drug abuse prevention, care, treatment, and rehabilitation programs.
2. Develop and implement a comprehensive and uniform plan for the prevention, care, treatment, and rehabilitation of narcotics and drug abuse throughout the State.
3. Establish goals and priorities for all State agencies providing narcotic and drug abuse services. All State governmental units operating drug programs or administering or subventing State or Federal funds for drug programs annually set their program priorities and allocate funds in coordination with SONDA.

II. DRUG ABUSE DELIVERY SYSTEM - THE STATE OF CALIFORNIA (continued)

Description of the System (continued)

4. To enter into such agreements and contracts with any persons, agency corporation, or other legal entity and such other actions as are necessary to carry out the purpose of this division (Division 10.8 of the J. and S.C.). The office may require State departments to contract with it for services to carry out the provisions for this division.

In 1972, the Federal government modified the role of SONDA by passing Public Law 92-255. This required states desiring to receive federal formula grants for drug prevention and treatment to designate a single state agency (SSA) to plan, allocate and manage the formula grant funds. SONDA was designated as the Agency by Executive Order Number R 41-73.

SONDA also prepared a State Drug Abuse Prevention Plan which was approved by the Federal government. As a result of the approval, California received new Federal grants in excess of \$11,000,000 for drug abuse prevention, treatment, training, research, and evaluation projects through a State-wide service contract.

SONDA is committed to plan and coordinate the State's Drug Abuse Program and not to administer and operate it. Consequently, the staff of the agency is kept small (approximately 10 people, plus clerical support) so that planning and coordination receive priority, and the actual prevention, treatment, training, research, and evaluation projects are carried out by other governmental and private agencies via contracts with SONDA. Examples of contracts include: an agreement with the Substance Abuse Branch (SAB) of the Department of Health; whereby, it administers NIDA monies to local drug treatment programs; a contract with a private foundation to conduct training programs for personnel in the Criminal Justice System and drug programs who are involved with penal code 100 (Diversion; and a contract with the Bureau of Criminal Statistics to maintain statistical information on P.C. 100).

SONDA sees itself as a broker of funds for drug services. It feels that this approach:

1. Enables the best available resource to be applied to a given project.
2. Frees SONDA to focus on planning and coordination.
3. Obviates the necessity of hiring additional staff, who may be less qualified than an outside resource, to conduct a project.

II. DRUG ABUSE DELIVERY SYSTEM - THE STATE OF CALIFORNIA (continued)

Description of the System (continued)

SONDA requires the development of a comprehensive and uniform plan for the prevention, care treatment, and rehabilitation of narcotics drug abuse throughout the State. This plan is required by 11942 (c) of the Health and Safety Code and is mandatory in order to receive NIDA funds. The State plan is supposedly based on county plans and input from all other State agencies which are involved with Drug Abuse.

SONDA's coordinating function involves reviewing the budgets and plans of all other State agencies which deal with Drug Abuse e.g., California Youth Authority, Department of Education, and the Department of Health. Although SONDA can make recommendations, it doesn't have the authority to direct changes in the plans or budgets of the agencies it reviews. Disagreements are resolved by the Agency which oversees the plan that was reviewed. For example, if SONDA disagreed with the Department of Health's plans, the matter would be presented to the Health and Welfare Agency for resolution. SONDA coordinates a total of 10 other departments of State government which deal with drug abuse. Of the 10, the Department of Health has by far the greatest impact on Alameda County.

The Department of Health

The Department of Health is most directly involved with community-based drug abuse programs. It directly administers Short-Doyle funds, and pursuant to an interagency agreement with SONDA, it administers several million dollars in NIDA money for the support of community programs. The Substance Abuse Branch (SAB) within the department administers the Short-Doyle and NIDA monies. The functions of the branch include:

1. Approving of and inspecting methadone programs.
2. Review and approval of county drug plans (Short-Doyle monies).
3. Provide technical assistance to local governments and community programs.
4. Review proposals for NIDA monies.
5. Evaluate all State supported drug abuse programs. SB 714 directed the State to develop an objective program evaluation methodology. The Drug Abuse Evaluation unit of SAB has been developing a uniform methodology to evaluate programs throughout the State.

II. DRUG ABUSE DELIVERY SYSTEM - THE STATE OF CALIFORNIA (continued)

The Department of Health (continued)

6. Administer all State and Federal formula monies which are contracted to counties or local programs.
7. Implement the Integrated Drug Abuse Reporting Process (IDARP).

This is a management information system which has three components: the client - Oriented Data Acquisition Process (CODAP), the Drug Abuse Prevention Resource Unit (DAPRU), and the Financial Management Information System (FMIS). CODAP provides information on the age, ethnic background, sex, educational level, employment status, and services received for clients in programs. DAPRU identifies all drug abuse facilities in California. FMIS is designed to provide financial management information on program operations.

The system is supposed to feedback information to State and local agencies from community drug abuse programs. This is a new federally sponsored project and is being conducted by the Program Information Unit of SAB pursuant to an interagency agreement based on a \$530,408 contract between SONDA and NIDA.

8. Collect drug abuse data.

SAB has set up a position with the Department of Health Program Analysis and Statistical Section (PASS). This position will collect drug abuse data such as number of drug related deaths, hospital admissions, and arrests.

Problems with the State System

1. Insufficient Needs Assessment:

It is repeatedly acknowledged in the State Comprehensive Drug Plan that the current needs assessment process is insufficient. On page 64 of the Plan it is stated that "... current data gathering efforts are inadequate . . ." The State also says on the same page, "It is through the development of a sound data collection system that the drug problem can be genuinely understood and deal with." On page 8 of the Plan it is asserted, "The existing data collection system does not permit an accurate assessment of trends in the drug problems, and therefore, resources cannot always be targeted to the areas of greatest need."

II. DRUG ABUSE DELIVERY SYSTEM - THE STATE OF CALIFORNIA (continued)

Problems with the State System (continued)

1. Insufficient Needs Assessment: (continued)

In addition to assessing needs for drug services the data base is viewed as being necessary to evaluate the efforts to combat drug abuse. Data collection systems are being developed, but it is frankly admitted that systems presently used by the State and Federal Governments are inadequate.

2. Insufficient State Evaluation Capacity:

For a number of years the State has spent many millions of dollars on drug abuse prevention and treatment without being able to determine the value of what was received. In fiscal year 1974-75 alone, \$73,143,000 in Federal, State, and local government funds were spent on treatment and rehabilitation in California (a total of \$97,808,000 was spent on all drug abuse related expenditures). These figures do not include private funds and many administrative costs.

Although an enormous amount of money has been expended, the State readily admits that planners and administrators at the State and county levels do not have adequate, on-going information on the relative payoff of drug abuse prevention and treatment services. Such information would include actual costs, utilization rates, short and long-term outcomes. As mentioned earlier, in 1972, SB 714 directed the State to develop objective evaluation methodology for drug programs. As of late October, 1975, the Drug Abuse Evaluation Project of the SAB, which is carrying out this mandate, was just finishing up the methodology to evaluate the operations of drug programs. This methodology will not include impact evaluation. It is hoped that by the beginning of 1976, the Project will be able to start developing the methodology for doing short-term impact evaluation. After that, long-term impact issues will be addressed.

3. The County Drug Plans, Which are Acknowledged as Being Inadequate, Form the Basis of the State Drug Plan:

In keeping with the intent of the Short-Doyle Act, the counties are given the responsibility to assess their own Drug Abuse Service needs and develop a plan. However, the State plan specifically admits that statistical sources relied on by counties are inadequate for the purpose of describing a drug abuse problem. Also, on page 58, the State plan indicates, "... few counties currently have the methodology, expertise, or resources to assess the effectiveness or efficiency of locally-funded programs." On the subject of county plans, the former Director of SONDA has stated that counties' needs assessments tend to be very subjective and involve too many political factors. A county

II. DRUG ABUSE DELIVERY SYSTEM - THE STATE OF CALIFORNIA (continued)

Problems with the State System (continued)

3. The County Drug Plans, Which are Acknowledged as Being Inadequate, Form the Basis of the State Drug Plan: (continued)

receive assistance in the preparation of its plan from regional SAB workers. However, this assistance is described as minimal. In regard to Alameda County's 1975-76 Plan, SAB has commented there was no correlation between the statistical information in it and the requests which were made. This would appear to be a common observation on county plans.

4. Lack of Harmony and Policy Coordination Between SAB and SONDA:

A degree of resentment is harbored by some staff members of SAB in regard to SONDA. They feel that they do all the actual work in drug abuse and are uncertain what SONDA does. Other staff members are aware of SONDA's role but feel there should be a merger of the two agencies. Some factors giving rise to this attitude are: (1) a legislative analysis concluded that coordinating agencies were unnecessary and have created an additional layer of bureaucracy; (2) that lack of clear policies has resulted in the duplication of certain activities.

In addition to the above, there are conflicts between the two agencies in regard to policy and philosophy. Conflict exists in spite of the fact that SONDA is supposed to review SAB's policies (although it does not have a veto power over them). Presently, SONDA is actively encouraging the development of innovative approaches to drug abuse prevention and treatment. SAB doubts this and follows what it considers to be a more realistic approach, i.e., people will always be attracted to drugs and other intoxicants, so there really is no cure. Thus, SAB will do its best to warn people of the consequences of drugs, and through programs provide abusers with decent environments where they can at least temporarily abstain from the use of drugs. A recently announced policy vividly illustrates the independence the Department of Health has from SONDA. On November 3, 1975, in a letter from the Community Services Division of the Department (the division SAB is in), it was declared that methadone maintenance is a modality of last resort, that new treatment slots will not be approved without substantial justification, and that program levels should be reviewed with a view towards shifting resources to other modalities. This policy represents the personal opinion of the Director of the Department of Health. It was arrived at independently of SONDA and even of some of the director's own staff. The reality is that the director is not reluctant to formulate and institute his own policy independent of SONDA.

II. DRUG ABUSE DELIVERY SYSTEM - THE STATE OF CALIFORNIA (continued)

Problems with the State System (continued)

Trends

This deals with apparent trends of the State and Federal Government in regard to Drug Abuse.

1. Federal Government:

NIDA will be allocating less funds for treatment. In fiscal year 1975-76, it is anticipated it will spend 1.2 million dollars less on treatment than in the preceding fiscal year.

NIDA is also about to lessen its commitment to funding training resources. The responsibility for this function is eventually to be assumed by the State. It is hoped by the State that NIDA will concentrate its resources on areas such as: developing better primary and intervention techniques, developing strategies to improve the probability of treatment success and researching the origin and patterns of drug abuse.

The State has suggested a number of responses to the decrease in NIDA monies:

1. With limited resources, emphasis must be placed on services to persons whose drug use is resulting in the greatest personal disfunction and negative impact on the community.
2. Existing agencies which are not primarily drug abuse oriented, should be used more readily for persons having minimal or secondary drug problems. In the past, the trend has been to place a person with drug involvement, no matter how minor or secondary to another problem, in a drug program or create such an agency if none existed.
3. Drug programs should pool certain common functions rather than attempt to provide a full range of services. e.g., it would be much cheaper to have one central job pool rather than each program having its own job developer.
4. Therapeutic Communities should adopt more economical approaches to treatment, e.g., make more use of outpatient treatment and provide for shorter live-in stays.

II. DRUG ABUSE DELIVERY SYSTEM -- THE STATE OF CALIFORNIA (continued)

Problems with the State System (continued)

2. State Government:

SONDA:

- a. As indicated previously, SONDA, under its new director, is pushing for the development of innovative approaches for drug abuse treatment. Also, SONDA is promoting the development of management information systems for the purpose of doing needs assessment and evaluation.
- b. The agency is also devoting attention to the needs of woman and minority groups.

SAB:

- a. The Director of Health is personally opposed to methadone maintenance and has established a policy to discourage its use. The Director feels it is preferable for a person to detox several times a year rather than rely on methadone maintenance. However, the Director is open to heroin maintenance. He does not intend for the Department itself to start a heroin maintenance project, but he has advised the Research Advisory Panel that he would be favorable to such a proposal.
- b. Outpatient opiate detoxification is being encouraged due to its cost savings.

Two additional significant points were made by State officials:

1. As mentioned before, within the SAB it is not realistically expected that a cure to drug abuse will be found. It is felt that as long as drugs exist, people will be attracted to using them. Therefore, the goal is to advise people of the consequences of using drugs and to provide modalities that will at least be a temporary, drug free refuge for them.
2. It was also made clear that drug abuse treatment is at best rudimentary. It is still a relatively new endeavor and definitely has not arrived at being a science or art. Yet, in spite of this, sacred cows already exist. Certain modalities and approaches are accepted as given without being questioned. This system may be supporting approaches which are unsatisfactory and thwarting the development of better ones.

II. DRUG ABUSE DELIVERY SYSTEM - THE STATE OF CALIFORNIA (continued)

Problems with the State System (continued)

Conclusions and Recommendations:

Although over \$97,808,000 was spent in the last fiscal year alone to combat drug abuse in California, the State cannot establish that results are being achieved. In fact, the State admits it lacks the capability to properly assess where resources would best be allocated. Further, it is unable to satisfactorily evaluate the impact of its expenditures. Finally, there does not appear to be uniformity of approach and purpose within the State Administrative structure.

In Light of the State's System, How Can Alameda County Work to Improve Its Drug Program Delivery System?

There are parallels which can be drawn between the problems found on the State level and those found within the County. In fact, in several areas which have been discussed, there is a direct interactional affect between both levels which compound the problems of each.

Alameda County needs to develop a formal communication network with the State so that crises can be better avoided. The State needs to be notified, in writing, not just when decisions create local confusion and hinder treatment effectiveness, but also when changes in the system can prevent future problems. Also, if local needs are assessed more adequately, and programs are evaluated more thoroughly, then the County will be in a better position to influence the State's decision-making and planning processes. Programs should not be funded through political pressure, nor should planning be based on biases not supported by hard data. A more rational approach to developing a drug delivery system, in the State and in the County depends on a definite future commitment to evaluation aimed at discovering what works best, for whom, and under what conditions.

III. PLANNING AND PRIORITY SETTING

Planning is one of governments least understood concepts and activities. It has many facets including specific planned zoning, generalized goal setting in a master plan design, and the development of specific program plans. All levels of planning are closely associated and the need to integrate them is recognized by most knowledgeable public managers. However, we often fail to organize planning functions with this in mind. It is not the purpose of this report to discuss planning in Alameda County but only in terms of the Drug Abuse Program. Therefore, we adopted the following definition of planning for the purpose of the report:

"Planning is the design of programs with specific objectives and activity descriptions; these programs indicate a choice among priority alternatives and are based on some indication of need."

III. PLANNING AND PRIORITY SETTING (continued)

A prerequisite for an effective drug abuse program in Alameda County is a comprehensive plan that describes:

- The size and nature of the drug problem.
- The available resources for dealing with the problem.
- A clear, measurable statement of program goals and objectives.
- The resources that are needed or desired to meet objectives.
- A strategy and time-phased plan to carry out the program.
- An evaluation plan and approach so that existing programs can be assessed and subsequent resources allocated more effectively.

In 1972, the State legislature recognized the need for such a plan and they passed SB 714. This bill requires each County to prepare a drug abuse plan to be submitted with the Short-Doyle Mental Health plan to the State Department of Health. The plan for 1975-76 was written by the Office of Alcohol and Drug Abuse and approved by TACDA, the Mental Health Advisory Board, and the Board of Supervisors.

Simultaneously, the Revenue Sharing Planning Board was discussing the allocation of Revenue Sharing funds - partially allocated to the drug abuse programs. Also, the Probation Department was preparing their budget for submission to the Board of Supervisors, and the Office of Criminal Justice Planning was working on their spending plan. Although Revenue Sharing proposals are reviewed by the sponsoring county department (in this case Health), the review should take place within the context of a comprehensive plan and established priorities.

The County Plan

The County Drug Plan developed by the Office of Alcohol and Drug Abuse contains a section called "County Data" that begins to deal with the size of the drug problem, but the statistics were not used to draw a picture of the true needs in the County. Nowhere does it describe how statistics should be collected on an ongoing basis to provide information for planning decisions. The Plan then goes on to state the top 10 recommendations and prioritized needs that were identified and supported by TACDA. None of the 10 relate to existing data, although one of them recommended that "Evaluation of all program modalities in 1975 is essential in order to obtain a reliable basis for planning in 1976." This seems to be in some conflict with another recommendation to "Maintain all (other) drug programs at no less than the present level of funding." This may be an indication of how the need for evaluation and the lack of planning tend to produce the status quo. The State Department of Health returned a formal comment on the Drug Plan to the County on September 10, 1975, and their analyst said, "There needs to be a clearer correlation between the description of the problem and the solutions proposed in the plan."

In all fairness to the Office of Alcohol and Drug Abuse, the Plan for 1976-76 was really the first one prepared by their office, and the State analyst did point out that " (the Plan) is an improvement over last year's Plan." He

III. PLANNING AND PRIORITY SETTING (continued)

The County Plan (continued)

also stated that "the Plan does an outstanding job defining the services being provided in each section of the County." Moreover, there are efforts currently underway to improve needs assessment for future development of a County plan. Also the drug planning activities incorporate considerable community and citizen involvement and this input is dealt with openly and honestly.

Planning Coordination

An important gap in the planning process is the need for input from the Criminal Justice system. Though there are criminal justice representatives on TACDA, Short-Doyle/SB 714 planning requirements are not geared towards a County-wide perspective, and as such, many criminal justice needs are not totally addressed. The Probation Department itself does not do the formal planning that is necessary to distribute the available funds for court diversion and post-sentence placements. Information on drug problems is gathered by informally polling Deputy Probation Officers and by reviewing computer records.

A "Criminal Justice" plan needs to be prepared by the Probation Department with input from city police, the District Attorney's Office, the Public Defender's Department, Probation Officers, and most importantly, the Court. This document should be blended with the Health Care Drug Plan so that a single comprehensive document is used as the basis for decision. Criminal Justice and Health Care representatives do meet regularly to discuss funding issues and other operational areas (the Health Care/Probation Coordinating Committee), but the minutes of these meetings indicate that this so far is not the forum for program planning decisions.

Priorities

In the absence of a formal needs assessment, and impact evaluations, drug program priorities are based on either the status quo, political pressure, inflexible State and Federal mandates or ingrained vested interests. This appears harsh, but our analysis clearly substantiated the conclusion. Time and again service providers and administrators and interested citizens referred to the absence of a basic rationale for funding and program priority decisions.

The Technical Advisory Committee on Drug Abuse (TACDA) has consistently stated that the top priority for funding should be in-County Therapeutic Communities. This may prove to be the best decision for drug treatment, but to assign priority over out-of-County T.C.s without evaluation of both alternatives and without fully identifying needs within the County is an example of questionable rationale for decisions.

III. PLANNING AND PRIORITY SETTING (continued)

Priorities (continued)

The preservation of the status quo appears to be a big factor in determining priorities. The statement in the County Plan that "All other drug programs should be maintained at no less than present funding," seems strange in light of other statements that admit to the lack of objectives and related rationale for such a decision. Funding decreases (such as the fold of TASC) result in a situation where all of the programs have their allocations reduced proportionately, regardless of quality.

The County badly needs to develop a master priority plan for the day funding decreases. We recognize the existence of a list of unmet needs which would be considered in the event of fund increases. Although we do not directly question their validity, decisions here are also subject to our commentary on the drug planning process.

The status quo should, over time, become subordinate to the need to develop innovative approaches to drug treatment. For example, the County should issue a Request for Proposal (R.F.P.) asking the community to submit ideas for new approaches to drug treatment. While it is agreed that the issuance of R.F.P.s could cause competition at the community level, client needs and requirements demand programs and services that work well and try to deal with a complex problem. These should come first. New funds are not necessarily needed in order for an R.F.P. process to be meaningful. The effective allocation of existing funds may be better served by asking programs to present new ideas for drug treatment. It is generally agreed that money for drug programs will be harder to obtain in the future and, as such, it is crucial that Alameda County prioritize its needs based on clinical evidence and proper evaluations.

The Pacific Institute for Research and Evaluation prepared a monitoring report on the Office of Alcohol and Drug Abuse in May, 1975. Though the monitor only spent one and a half days on site, she had been familiar with other drug coordinating functions and many of the findings still appear to be relevant. The Health Care Services Agency responded to the criticisms contained in the report by writing to one member of the Board of Supervisors (with a copy to the CAO) "and indicating that criticisms in the report were being considered in the reorganization of the agency." While several of the issues relative to the operation of the methadone clinics and the internal operations of OADA have been addressed, our evaluators found the following points made in the report still need improvement:

" . . . the Office's major decisions regarding funding and policy are based not on clinical and management assessments, but on political and status considerations."

"The Office's monitoring and data collection systems are badly inadequate at present, and rational, long-range planning is consequently an impossibility."

" . . . The Office suffers from a lack of information about the incidence and prevalence of drug use . . ."

IV. FUNDING MECHANISM

Introduction

The attached chart (Exhibit A) details the flow of funds from the Federal government, the State, the Office of Criminal Justice Planning, Revenue Sharing, the County General Fund, and "other" sources such as city funds and patient fees through OADA and the Probation Department to the community programs. Exhibit B lists each program and their source of funds for 1975-76. These exhibits present a picture of the size and complexity of the funding mechanism.

Role of the State

State role and procedures in funding local programs is a key issue. Decisions by the Office of Narcotics and Drug Abuse (SONDA) are often the result of last-minute political decisions that leave the County in the position of having to abandon or at best be cynical about planning. This also results in enormous time being spent in pursuing State dollars. For example, the funding of the Probation Department's Treatment Alternatives to Street Crimes program (TASC) ended (presumably due to NIDA's failure to include them in the 1976-76 budget) and the County was forced to fund the court diversion slots through a new pre-Trial Services division. As a result, contractual rates dropped from \$12.33 per client day to a variable rate negotiated with community programs in an attempt to stretch the money as far as possible.

Problems facing the County in its relationship with the State and the National Institute for Drug Abuse (NIDA) are demonstrated by the following statement received on September 5, 1975, from the chief of the Drug Abuse Section of S.A.B.:

"The State cannot process any 409 contracts with programs or counties (effective October 1, 1975), through the State review agencies until the contract between NIDA and SONDA and an Interagency Agreement between SONDA and SAB are fully approved. Processing . . . will delay the approval of individual program and county contracts. This means that we will not be able to make payments for the month of October until probably late December."

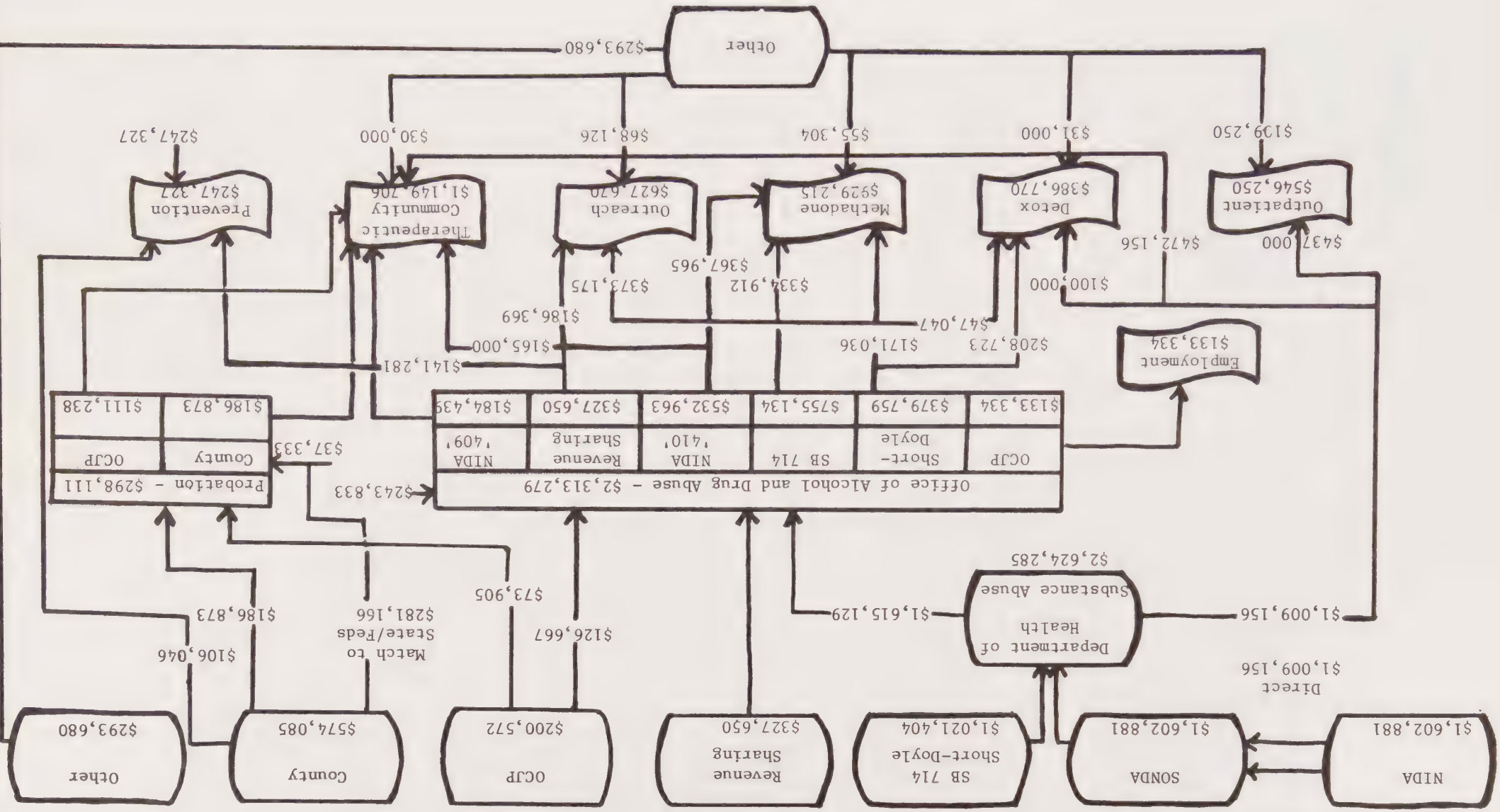
The result of this delay in State funding support meant that the County had to absorb the cost of two drugs programs (GROUP and Project Eden) for the expenses covered in the State contract until the State gave final approval to the grants and reimbursed the County. If the State did not approve the contracts for some reason, the County would have had to bear the cost.

Greater attempts should be made by OADA to make the State more aware of the impact their delays and confusion have on the drug programs in Alameda County.

County officials have dealt very successfully in the past in getting cooperation from State and Federal officials on funding issues. However, more attention needs to be paid to improving the systems and procedural problems caused by the State and Federal agencies. For example, the State might be asked to allocate funds to a contingency account used to maintain programs when State delays result in delays in program funding.

1975-6 Allocations
Total = \$4,020,272

\$593,725
409/410



IV. FUNDING MECHANISM (continued)

Multiple Funding

Both Exhibit A and Exhibit B illustrate the problem of programs receiving funds from many sources. Multi-modality programs receive funds by submitting a proposal to agencies that are structured to fund only one modality. This causes planning and evaluation of the programs to respond to narrow funding agency requirements. It also causes auditing and management difficulties. Benefits from having a "care continuum" resulting from multi-modality programs outweighs the confusion caused by different funding sources. However, not only does effort need to be made in relieving the obvious administrative and technical burden of multiple funding, but local controls need to be established on the basic planning evaluation process.

A positive step in relieving the problems caused by multiple funding is the Short-Doyle system. Here most programs receive their funds through SB 714 allocation which identifies drugs as a special allocation and creates a single funding mechanism. The Drug Coordinator is attempting to convince the State to transfer all funding to the SB 714 mechanism to ease the administrative burden and eliminate a duplicate source of funds. In addition, a recent County policy decision of having OADA negotiate all local drug contracts will help the multiple funding problem.

At the County level, multiple funding is further complicated by programs receiving funds from the Health Care Services Agency, the Probation Department, Revenue Sharing, and the Office of Criminal Justice Planning. Although contracts and operational problems are now jointly reviewed at the Health Care/Probation Coordinating Committee, there is still a need for local coordination of planning. The administrative responsibility for all drug programs that contract with the County should rest with the Health Care Services Agency to assure fiscal and performance consistency. Probation's contracts with the Therapeutic Communities were based on its responsibility for TASC. However, County funds have replaced NIDA money and the Pre-Trial Services Division has replaced TASC. Pre-Trial can place its clients in a variety of programs - whether the slots are reserved by contracts or not. Therefore, the rationale for Probation accountability in T.C. contracts is changed. Any comprehensive plan should identify and negotiated contracts reflect "reserve slots in the T.C.s for court diversion referrals to avoid the situation in the methadone clinics when waiting lists are too long to permit effective placements of Pre-Trial clients. The determination of the number of slots required by Probation should be arrived at through the planning process. NIDA regulations require that methadone programs make 10 percent of their authorized slots available for court diversion referrals. However, implementation was not achieved because available slots and support funds from Probation never happened at the same time.

Our evaluation does not address the pros and cons of methadone maintenance as a treatment modality. However, the lack of court diversions or conditional probation slots in the programs, combined with an expressed interest on the part of the Probation Department to have such slots available as an alternative, points out the need for adequate comprehensive needs assessment (i.e., how

IV. FUNDING MECHANISM (continued)

Multiple Funding (continued)

many people would the Court divert to methadone programs?) and coordinated planning. This should address:

- How many court diversion slots will be needed? (A current study of the Office of Criminal Justice Planning is attempting to address this issue)
- What treatment modalities appear to be most effective and for what type of Criminal Justice client.
- What needs are there for alternate treatment modalities as perceived by Criminal Justice.
- The need for evaluation criteria to assess the effectiveness of drug program placement on persons referred from the Criminal Justice System.

Finally the Office of Alcohol and Drug Abuse should continue to more aggressively pursue the concept of planning and funding on a regional basis with neighboring counties. Many expensive programs could be combined to provide two or more counties with improved facilities.

Evaluation

Planning, as defined in this report, and evaluation are very much interrelated. It is difficult to plan without both, an evaluation of the existing resources and programs. Evaluation must reply on the goals and objectives defined in the planning process. The 1975-76 Drug Plan outlines the steps to be taken by the Evaluation Subcommittee of TACDA to develop evaluation criteria, but much more needs to be done. The Drug Coordinator should give a high priority to the development of an evaluation mechanism and request funds for it from the Board of Supervisors.

In a 1974 report to the Office of Criminal Justice Planning by JRB Associates entitled, "Cluster Evaluation of Narcotics Coordinating Projects" the authors stressed the need for evaluation to be both ongoing and impact oriented. To date, this has not been accomplished. The Office of Alcohol and Drug Abuse seems to be faced with many crises that supersede placing a high priority on evaluation. Two critical areas should be subject to evaluation:

1. The comparison of the effectiveness of different forms of treatment and
2. Follow-up on clients that have left the drug programs.

IV. FUNDING MECHANISM (continued)

Evaluation (continued)

The current evaluation by OPE (see sections on Methadone and Therapeutic Communities) is filling this need now. However, ongoing capacities should be developing as part of program planning and evaluation. Regardless of the sensitive nature of confidentiality, efforts need to be made by the Health Care Agency and Probation to discover what happens to people after they leave a drug program or to find out why they leave.

There is lack of coordination among the various agencies conducting evaluations. There were complaints that the evaluations were repetitive and superficial; that the evaluators were ignorant of basic drug issues; and that the programs did not receive constructive feedback. Our evaluators were unable to verify the accuracy of the complaints, but judging from the evaluations we read before beginning our study, we would have to agree that the results may not have been worth the energy required of the programs. This area of multiple evaluations is one of many problems associated with the multiple funding of drug programs.

V. ADVISORY STRUCTURES - TECHNICAL ADVISORY COMMITTEE ON DRUG ABUSE (TACDA)

TACDA was created in December, 1972, when the California State Legislature passed Senate Bill 714, establishing section 5606.5 of the Welfare and Institutions Code. This required each local mental health advisory board to have a technical advisory committee on drug abuse. The committee was to consist of "representatives of law enforcement agencies, private and public drug programs, drug programs, education, and the general public selected by the Board of Supervisors.

The role of TACDA is described in SB 714 as:

1. Review and evaluate the community's drug program needs, services, facilities, and special programs.
2. Review the drug portion of the County Short-Doyle Plan.
3. After adoption of a program, continue to act in an advisory capacity to the County Drug Program Coordinator and the local mental health advisory board.
4. Report its findings and recommendations to the County Drug Program Coordinator and the local mental health advisory board.

On September 12, 1975, the Governor signed AB 2119 which amended the section in the W & I Code that created TACDA. The bill abolished the technical advisory committee on drug abuse and transferred its activities to a new county advisory committee on drug abuse.

V. ADVISORY STRUCTURES - TECHNICAL ADVISORY COMMITTEE ON DRUG ABUSE (TACDA) (continued)

This new advisory committee may either be independent or under the jurisdiction of the mental health advisory board. The option is the Board of Supervisors'. The duties of the new committee would be the same as those of TACDA except that they will report their findings only to the County Drug Coordinator, and not to the mental health advisory board. This bill further established drug abuse as a problem that should be administered independently of mental health issues. The County Board should formalize an operational reality by exercising its option to make the new advisory committee independent of the mental health advisory board.

Membership

Previously the Board of Supervisors appointed 10 members and designated 10 other representatives from County departments to deal with the drug problem on TACDA. All 20 of the members serve for an unspecified length of time - presumably at the Board's pleasure.

The passage of Proposition 9 presented many of the members of TACDA with a possible conflict-of-interest that resulted in several members resigning and being replaced by non-providers. County Counsel feels that it is a conflict-of-interest for members of an advisory board to receive funds from the organization they are "advising," but to date no legal action has been taken and several providers are still on TACDA. However, they abstain from voting on issues that directly relate to their programs. TACDA's intensive involvement in funding-policy decisions is exemplified by the following:

- On August 8, 1975, TACDA voted to ". . . submit a recommendation to the Board . . . that all out-of-county placements be phased out by attrition."
- Recently TACDA has written the Board urging that Therapeutic Communities be insured County funding should State sources decrease. This is inspite of the lack of evaluative data addressing the quality of the T.C.s and inspite of statements from N.I.D.A. representatives that Alameda County is overcommitted to T.C.s as a treatment modality.

Both examples point out TACDA's concern with insuring the continuing of existing community programs and in being involved in issues that go beyond "technical assistance." TACDA's role exceeds its 1972 legislative mandate, in that it is involved in making recommendations on the distribution of funds and establishing policies and priorities that give preference to individual programs. Activities dealing with true technical advise (such as evaluation criteria and planning mechanisms) are not given adequate attention. There are three major conflicts which make it difficult for TACDA to give advise which could be considered either technical or valid:

1. TACDA is staffed by the Office of Alcohol and Drug Abuse. This prevents important distinctions between an advisory role and a Health Care line agency. OADA staff support of a group which is supposed to take an impartial look at OADA is, at best, inconsistent.

V. ADVISORY STRUCTURES - TECHNICAL ADVISORY COMMITTEE ON DRUG ABUSE (TACDA) (continued)

Membership (continued)

2. Some TACDA members are directors of programs which receive funds from the County. Even though the directors do not vote on funding issues that affect their programs, their presence on TACDA places other program directors at a disadvantage when their programs are discussed. This conflict also leads us to question whether TACDA recommendations reflect the best approach for the total County Drug Program or are the results "trade offs" on the needs of each program.
3. The County department representatives on TACDA are employees of the departments which have a direct interest in the operations of the drug system. Here, too, pressure exerted by department heads could influence the TACDA representatives and the impartiality and perspective of TACDA become suspect. Also, many of the County representatives have not been attending TACDA meetings due to their own time limitations (the Superior and Municipal Court representatives have not attended one meeting in the past year). SB 714 requires TACDA to consist of representatives of various County departments, there is no requirements that they be employees of them.

Recommendations

To establish the need for an impartial forum for community and advisory input into drug system decisions and to relieve the above conflicts we recommend that:

1. The new Advisory Committee on Drug Abuse (ACDA) should respond directly to the Board of Supervisors and provide assistance to the Drug Coordinator as required. It is important that the Advisory Committee on Drug Abuse relate to the Board to make its advice and counsel an active and impartial part of setting policy/priorities for the Drug Program. This will free the Committee from under staff pressure and bias. This may be interpreted as a violation of SB 714. However, we do not see the primary ACDA-County Board relationship with input to the Drug Coordinator as required as necessarily in conflict. We would anticipate a County Counsel ruling. ACDA's duties would include:
 - Advice to the Board as to a comprehensive plan and priorities for drug services.
 - Serve as a funnel for community input.
 - Participate in the drug program planning process.

V. ADVISORY STRUCTURES - TECHNICAL ADVISORY COMMITTEE ON DRUG ABUSE (TACDA) (continued)

Recommendations (continued)

2. To emphasize ACDA's independence from the Drug Coordinator and to insure an adequate and impartial information flow, ACDA should have its own staff consisting of an Administrative Service Assistance II and a clerical position. This would cost approximately \$29,290 per year (salary plus 20 percent fringe benefits minus 10 percent savings).
3. The County departments currently represented on ACDA should appoint non-County employees to replace their current representatives.
4. Community representatives should not be employees of any program currently receiving any State, Federal, or local funds.
5. ACDA should not routinely be presented funding allocation recommendations for their approval. The Drug Coordinator will have the responsibility for presenting the Drug Program Plan, which should be reviewed by ACDA but routine funding decisions should not be submitted for ACDA "approval."
6. Attendance reports should be used to notify the Board of appointees who chronically miss meetings so that they may be replaced. The Office of Alcohol and Drug Abuse recently submitted an attendance report to the Board and we hope this becomes a regular practice. As previously mentioned, some of the above recommendations involve at least an interpretation of present State law and possibly some change in the law. However, the need for clarification of roles in the Drug Program is badly needed.

Communications

The communication network among OADA, the community programs, the Board of Supervisors, the State and Federal Governments, and various County departments is an important indicator of delivery system effectiveness. The monitoring report prepared by the Pacific Institute recommended a more formalized communication system that involved more careful dissemination of the decisions that are made so that "the crisis atmosphere might be alleviated and to produce better coordination." Our evaluation team agrees wholeheartedly.

At the present time, there is no formal means of communication between OADA and the programs, and information is provided through memos, letters, workshops, or TACDA meetings. We recommend that the office institute a numbered policy or general information bulletins that would provide a chronological sequence of decisions and information. A monthly newsletter should be used to keep all of the programs up-to-date on important issues, or the Office of Alcohol and Drug Abuse could coordinate information distribution through the County school's drug newsletter, "Links."

V. ADVISORY STRUCTURES - TECHNICAL ADVISORY COMMITTEE ON DRUG ABUSE (TACDA) (continued)

Communications (continued)

The size and complexity of the entire drug system hinders effective communications. There have been times when the State has communicated directly with certain program directors and failed to provide copies of the communication to the Drug Coordinator. This compounds the problems.

Timely and continuous communications with the County Board needs more emphasis. It is crucial that they be aware of the issues and needs in the drug field so that decisions are relevant and based on fact. Information flow to the Board is complicated by two problems:

1. Board members are not being provided feedback by their appointees to TACDA. Some Board members had only talked with their appointees once or twice in the last year. For the appointee to adequately represent the Supervisor and to keep him informed of issues, more feedback should occur and probably on a more formal basis.
2. Program directors often contact Board members directly. While this does not violate any trust and is necessary and important in many situations, it is also important that all parties concerned be aware of the contact and subsequent decisions. The possibility of confusion that may arise should be recognized and agency staff responsible for contract administration be kept fully informed.

An important role of the OADA is to inform the programs of pending Federal, State, and local issues. There is feeling among some of the program directors that this area needs improvement. Its relationship to preparing a comprehensive plan is obvious. This information was provided in the drug program directors' responses to the mailed questionnaire sent out by the evaluation team. Six respondents specifically referred to the need for improved communications. Only one respondent out of 12 indicated no problems with communication.

V. SUPPORT SERVICES

Community-based programs that contract with the County receive assistance from various County, State, and Federal departments to help them operate as effectively as possible. The issue of whether or not these support services are adequate is a very important to the success of the drug delivery system. Programs are concerned about the need for more assistance in setting up and maintaining bookkeeping systems that meet the requirements of the County Auditor. Many programs do not have the expertise to establish adequate accounting systems, and since funds are rarely diverted from direct to administrative services the result is confusion and disallowances when the Auditor analyzes the books at the end of the contract period. The fiscal analyst at OADA provides some assistance to programs, as do various auditors who understand that front-end help will result in an easier audit. However, it is not the auditor's

VI. SUPPORT SERVICES (continued)

responsibility for fiscal integrity of the program's books. Programs should understand what their obligations are in the accounting fields and then provide the mechanism or resources for adequate reporting. In Santa Clara County, the Auditor assists the programs in setting up the books and then, approximately one month into the contract period, a "trial" audit is performed and results analyzed. The Alameda County Auditor, may want to review the Santa Clara procedure to analyze the concept and the success of their procedure.

The Auditor and OADA are considering holding workshops to familiarize the programs with sound accounting systems. This office strongly recommends that these projects be given a high priority. We also recommend that the Auditor with Health Care Services Agency's assistance, prepare a procedures manual that will help the programs better understand the accounting requirements of the County, State, and Federal agencies. Should this assistance fail to produce adequate accounting systems, the agency responsible for administering the contracts should consider requiring that all programs have their books approved and/or maintained by a CPA or other professional bookkeeper.

State and Federal agencies make various support services available to the County and to the community programs. Their content and the quality is an important part of the delivery mechanism. The Substance Abuse Branch of the State Health Department assigns a Community Program Analyst (CPA) to each state region to assist the County in a variety of areas ranging from producing the County Drug Plan to preparing the County budget. He also reviews community proposals and the County Short-Doyle Plan. The CPA is utilized as a referral agent when he does not possess the technical skills required to meet the needs requested of him.

The National Institute of Drug Abuse (NIDA) contracts with numerous private consultants to provide assistance in the areas of program management, medical and counseling management, and recordkeeping. The quality of these services is questionable in that one program did not receive requested services for six months and even then they did not feel the aid was of any significant value. NIDA also contracts with the Western Regional Training Center to provide courses in many drug related subjects and supports the West Contra Costa Health Care Corporation to provide paraprofessional training to drug counselors.

There are general educational consultation services provided by the Alameda County Drug Education Center which received praise from many of the program directors. The quality of State and Federal support services was judged to generally be poor by the directors.

The Office of Alcohol and Drug Abuse attempts to provide support services to the contractual drug programs. The Office is committed to providing administrative (preparation of budgets and proposals, interpretation of State and Federal regulations), technical (how to take clinical notes and maintain files, how to fill out forms), and clinical assistance (consultation on individual cases, content of treatment programs). They provide these services either by referral, in-house staff, or by hiring a consultant.

VI. SUPPORT SERVICES (continued)

We question the concept of OADA providing support services to the contracting programs. The County has contracted with these programs to provide a specified service and to be accountable for the quality of that service, and at the same time seems to be questioning the validity of that decision by spending additional resources on technical assistance and related support activities. If administrative, technical, or clinical assistance is needed programs should be given money to independently obtain those services. The responsibility for assessing and obtaining the needed support should lie with the people responsible for delivering the direct service - the programs.

In assuming the responsibility for providing assistance, OADA is compromised when it comes to planning and evaluating programs and administering contracts. The roles are ambivalent and conflicting. Programs which look to OADA for assistance can claim less accountability for performance when the assistance is less than adequate. Furthermore, the needs of the programs can be very diverse, and it is unrealistic to expect one office to be able to meet all requirements.

Recommendations

- The Office of Alcohol and Drug Abuse should not provide support services to the programs. However, it is incumbent and on the County to clarify all procedures and requirements mandated by the County.
- Contracts should contain provisions for assistance in support services.
- The Health Care Agency should act as a resource to programs in the selection of various forms of assistance.

VII. CRIMINAL JUSTICE AND THE DRUG DELIVERY SYSTEM

A number of individuals were interviewed representing the Judges, Probation Department, and other criminal justice units relating to the County's drug programs. All of the judges interviewed welcomed placement or sentencing alternatives in spite of preconceptions as to drug program effectiveness. The judges were realistic in their assessment of level of program impact. This, along with some feelings as to depth of program impact and accountability, is traced to the need for more information being provided to the Courts. All persons interviewed were quite desirous of having information on the performance of individual programs and on the impact of drug treatment. Courts most frequently refer cases to Therapeutic Communities and have minimal contact with Methadone and Outreach programs. Methadone maintenance placements usually involve a defendant who was already in a methadone program at the time and who desires to stay in the program as part of the disposition of the case.

VII. CRIMINAL JUSTICE AND THE DRUG DELIVERY SYSTEM (continued)

The judges were unaware that due to long waiting lists, the Probation Department was not recommending methadone maintenance for unsentenced defendants who want it. Some of the judges commented that inadequate screening procedures permit too many insincere and unmotivated people to be placed in programs, and that this creates problems for all parties concerned.

Information on Programs

Some of the ways the courts receive information on drug treatment programs are discussed below. With so many diverse sources of information, it is difficult to sort out which are reliable or meaningful.

1. Court Personnel: One of the primary sources of information regarding programs are court personnel such as probation officers, pre-trial service workers, defense attorneys, and district attorneys. The information received from these people is basically impressions and not factual data.
2. Program Court Liaison Personnel: Program Court Liaison Personnel will frequently contact the courts on individual cases.
3. Workshops: Approximately three years ago, the Drug Abuse Program Unit of the District Attorney's office sponsored a workshop where representatives from local programs spoke to the courts about their program.
4. Fellow Judges: Information can also be received from fellow judges informally or through regular meetings. However, it does not appear that drug treatment is priority topic of discussion at the meetings.
5. Judicial Pre-Trial Coordinating Committee: This committee is composed of one judge from each Municipal Court Judicial District and one judge from Superior Court. It is staffed by the Pre-Trial Services Coordinator's Office. The heads of the Pre-Trial Services Division and the Probation Department, representatives of Berkeley's O.R. Project attend committee meetings. The Superior Court Judge has been represented at the meetings by the Court Administrator. This committee is a new source of information on drug treatment.

So far, specific programs have not been discussed at any length. However, areas such as the recent decline in referrals to drug treatment programs, need for in-depth study of the drug usage problem in Alameda County and the effectiveness of current programs have been agenda items. This committee is seen as having a high potential for providing information and participation on drug treatment to the courts.

VII. CRIMINAL JUSTICE AND THE DRUG DELIVERY SYSTEM (continued)

Information on Programs (continued)

6. TACDA: Both a Municipal Court Judge and Superior Court Judge are members of TACDA. However, in the last year, neither judge has attended meetings. As members they receive the minutes of all meetings, but by missing the meetings they do not have the opportunity of presenting the bench's point of view.
7. "Splitees from Programs": Information on splits is important to the courts. No formal records are kept, but the courts are sensitive about it and take great issue with programs that fail to report. The courts especially prefer that the programs notify them in writing immediately upon a person's "splitting." Improper reporting and/or lack of reporting, have been a problem in the past. Presently, the situation is improving.
8. Statistical Information on Programs: Limited statistical information is kept. Even so, as is discussed below, much of what is known is not disseminated to the courts.
 - a. Pre-Trial Services: Pre-Trial services has done some monthly spot checks to establish the split rates of drug programs used by Alameda County. However, this information is kept in-house and is not disseminated to the courts. Pre-Trial Services is also keeping data on the number of persons interviewed, those admitting a drug problem, and those interested in treatment.
 - b. Pre-Trial Services Coordinator's Office: This office has just started receiving statistical information as of the month of December, 1975. The office is providing contractors with a form which calls for information on the number and sources of referrals during the month and the split rate of Pre-Trial Service placements. This data is duplicative of that which is being collected by Pre-Trial Services. To date, it has not been decided whether this information will be disseminated.
 - c. Probation: The Probation Department is currently maintaining monthly statistics on the number of available contracted treatment slots and how many are actually being used. This information is publically available and is distributed at the biweekly Probation/Health Care Services Committee meeting.

VII. CRIMINAL JUSTICE AND THE DRUG DELIVERY SYSTEM (continued)

Information on Programs (continued)

9. TASC: The TASC project, which went out of operation in June of 1975, kept very detailed statistical information on its contracted programs. Data for the period April 1, 1974, to December 27, 1974, is contained in the TASC 1974 Operations Report. The data included split rates which were broken down into eight specific time periods starting with the split rate in 0-7 days, then 8-30 days, and so on. The data also included statistics on the average number of days placements stayed in a program.

The 1974 Operations Report, in which the statistics appeared, also contained a lengthy description of each of the contracted programs. However, this report apparently was only provided to Oakland Municipal Judges.

Historically, a rift has existed between the Criminal Justice System and Health Care Services. The Criminal Justice System preceives Health Services to be unresponsive to its requests to provide alternate methods of dealing with defendants in the criminal justice system. The usual explanation for this conflict is a difference in philosophies. It is alleged that Health Care Services feels a person must willingly and voluntarily seek treatment to benefit from it; whereas, the criminal justice system is seen as being responsible for placing people in treatment who do not necessarily volunteer.

It was generally stated by the courts that Health Care Services does not solicit their comments and input on the drug treatment services.

The courts are aware that requests by defendants for referrals to drug programs are definitely on the decline. This point was also brought out by the judges at the Judicial Coordinating Committee. The accepted explanation is that many of the defendants currently coming through the system have been in programs previously and are not desirous of being referred again.

In November 24, 1975, letter to the Director of Pre-Trial Services from the Pre-Trial Coordinator, the following problems were identified as contributing to a low referral level for local in-patient drug programs:

1. General confusion associated with program funding.
2. The Judiciary is dissatisfied with the quality of local programs.
3. The in-County programs are too "attack oriented in their treatment approach and have weak programs.
4. Individual program management and fiscal problems necessitated a reduction in referrals to some programs.

VII. CRIMINAL JUSTICE AND THE DRUG DELIVERY SYSTEM (continued)

Information on Programs (continued)

It should also be mentioned that the Pre-Trial Coordinator thought that many of the circumstances that indicated reduced referrals had changed. The courts had no suggestions for additional services at the community level. However, some of the judges expressed a desire to have a treatment program in a jail or prison which could help defendants in need of treatment, but at the same time protect the community. Santa Rita did have a drug program sponsored by the Probation Department, but it was closed down in the first half of 1975. It would seem appropriate that Probation and Health Care Services explore the feasibility and potential benefit of re-establishing such a program.

Recommendations:

1. The courts need to receive more factual information as to the impact of drug programs and they need to be more active in availing themselves of that information.
2. The Criminal Justice System and Health Care Services need to plan more actively together, and their planning should include input from the courts.

VIII. OFFICE OF ALCOHOL AND DRUG ABUSE

This section will address the role of OADA with respect to the Drug Program. Its relationship to alcohol treatment services will be the subject of a future evaluation by OPE. The importance of this office's functions to the drug delivery system cannot be overstated. It is the focal point of many decisions and recommendations, and as such, should establish the purpose, direction, and content of the County's drug program.

The duties and responsibilities of OADA should extend beyond the scope of the SB 714 legislation. The County as a whole handles four million dollars in drug-related funds, spread across several departments. Due to a variety of reasons, both internal and external, we must give more attention to planning, priority setting, and evaluation. However, there are many inherent conflicts built into the role and basic mission of OADA that make this virtually unachievable.

These are:

- The office is supposed to assist programs develop proposals and at the same time review and recommend proposals for funding.
- They provide technical assistance to programs and then monitor the program's operations.

VIII. OFFICE OF ALCOHOL AND DRUG ABUSE (continued)

- They work within the Health Care Services Agency but are supposed to integrate Criminal Justice and educational needs and priorities.
- They staff the committee that is supposed to advise them.
- They are directly responsible for the management and evaluation of two County methadone programs and the evaluation of the two other private methadone programs. This is bound to cause conflicts when and if the funding decreases for methadone programs.

There is a gap between the need for long-range conceptual and program planning and the amount of time the OADA spends on it. The emphasis is on day-to-day operational problems, with the result that the Office cannot plan a County drug service or system in a way that is required.

This combined with previous doubts on the real need for "coordinating" and providing support services indicates the need to look at the role of the office.

Recommendations

The dichotomies and conflicts in the office's present role must be recognized. The resolution of the problem can be achieved by implementing one or a combination of the following alternatives (These are discussed in terms of the issues):

Planning

The reader is asked to recall the definition of planning outlined in an earlier section. Clearly planning in the Drug Abuse Program needs definition, clarification, emphasis and additional resources. It needs to be recognized as a discreet activity requiring specialized skills and a unique, responsive process. It is different from evaluation and line activities. Also, the same individuals doing planning, technical assistance, contract administration and evaluation probably do not achieve adequacy in all areas and get into conflicts in role. Program planning which involves more than one department or agency places additional requirements on personnel. The following recommendations are appropriate.

We recommend:

1. That a comprehensive on-going needs assessment be designed and implemented and that it be supported by an integrated information system that coordinates all present statistical and subjective reporting.

VIII. OFFICE OF ALCOHOL AND DRUG ABUSE (continued)

Recommendations (continued)

Planning (continued)

2. That an annual, comprehensive County-wide Drug Plan be developed that states and describes program needs, goals and objectives; the plan would describe the total program regardless of agency responsibilities.
3. That a list of program priorities with alternative sources and methods of funding be incorporated in the above plan and be presented to the County Board as part of the yearly budget process. Funding decisions should reflect the priorities in the plan.

There are a number of alternatives which are "workable" in implementing these recommendations and at the same time begin to address the conflict problems inherent in the present role of OADA. Additional factors influencing the options are the interdepartmental nature of the drug program and the unique nature of program planning requirements.

Alternative I

The County Administrator's Office:

This option would transfer all program planning activities as described above from OADA and place them in a newly created Drug Planning unit in the CAO's office. This transfer is recommended on a functional basis. Personnel transfers or additions should be decided during actual implementation. Exhibit D shows a possible staffing pattern and budget for the new unit. This option has a number of advantages over the present system. They are:

1. It separates the planning function from potential conflict with administration, contract administration, monitoring, and related activities.
2. It gives the planning function a high priority and more visibility as part of the total drug program.
3. It resolves the problem of agency and departmental preference by assigning planning to an organization that does not have a built-in vested interest and is comprehensive in perspective.
4. The transfer is compatible with present legislation (SB 714).
5. It tends to integrate planning and budgeting and would tie together program and fiscal decisions.

VIII. OFFICE OF ALCOHOL AND DRUG ABUSE (continued)

Recommendations (continued)

Planning (continued)

6. Placement in CAO's office would establish closer relationships between the planning process and input from ACDA particularly if our recommendation to have ACDA report to the County Board is adopted.

Acceptance of this option also has some disadvantages. These include:

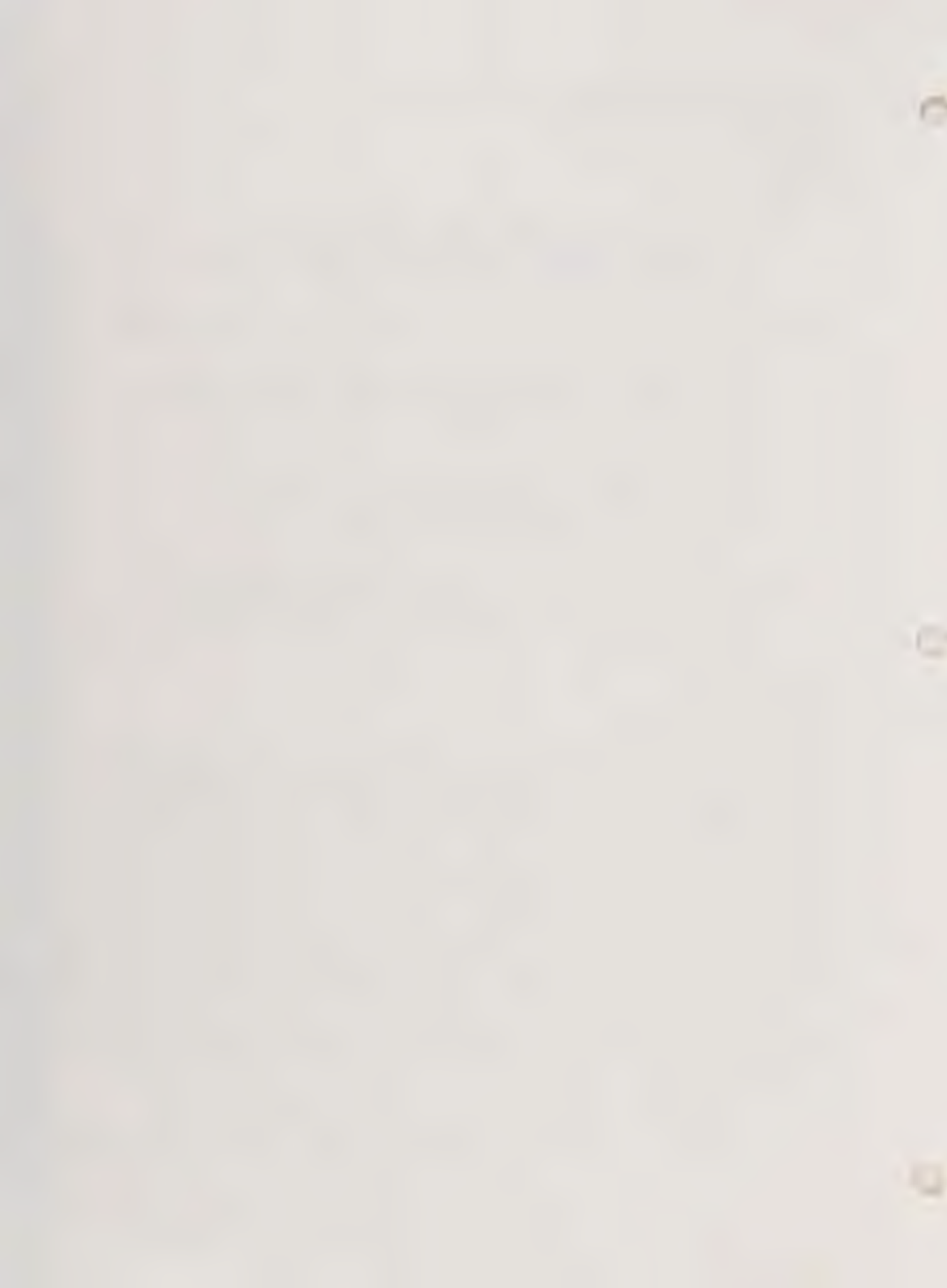
1. It introduces planning to an office (CAO) which has traditionally dealt with budgeting fiscal, organizational, and general operational issues. In these situations integration is always difficult.
2. It removes planning from the program level and places great demands on the planners to design a planning procedure which ensures adequate participation and input by all involved drug program units.
3. It may be time consuming in that the CAO will have to invest considerable time in producing the comprehensive plan, and it must be "bought into" by service providers in the agencies.

Alternative II

Continue Present Model

The present mechanism for producing a comprehensive program plan (OADA and TACDA and Program Directors) should be considered as an alternative. This would become slightly more acceptable if a sincere effort were made to redistribute duties among OADA staff to nullify the impact of the built-in conflicts discussed in our analysis. This course of action might result in internal separation of planning and evaluation (monitoring), the exclusion of technical assistance (whatever variety) from contract administration and monitoring and recognizing proposal review and contract negotiation as discreet activities. In addition, the role of program advocate whether applied to funding requirements or liaison work with the County structure compromises individuals performing the above duties. However, any action adopting this alternative must recognize basic questions raised about role and contribution of OADA. Also, responsibility for that office rests with one individual and we are questioning the basic design of the office with respect to program planning. Nevertheless, we see advantages to this alternative. Specifically:

1. It would be the least disruptive over present procedures.
2. It would cause the least dislocation and/or transfer of personnel.



VIII. OFFICE OF ALCOHOL AND DRUG ABUSE (continued)

Recommendations (continued)

Alternative II

Continue Present Model (continued)

3. It could use a reservoir of good will and contacts built up by OADA.
4. It would help to make important distinctions between line (two County methadone programs) and staff relationships in OADA.

The disadvantages are identified in earlier sections of this report.

Alternative III

Health Care Agency

Retention of the planning and evaluation functions in the Health Care Agency but outside of OADA is the third workable option. HCA might create a drug planning and evaluation unit at the agency level reporting to the agency director or assistant director. The unit's role and specific duties would be basically the same as described in Exhibit D. Also we would anticipate that the proposed budget and staffing pattern contained in the same exhibit would be applicable. Again with any move toward centralization, citizens, and service providers must be included in the planning and evaluation process. Some advantages and costs of this approach are:

Advantages

1. It would help to resolve OADA functional conflicts.
2. Raise drug planning and evaluation to the needed priority level in HCA.
3. Help to create more effective communications within HCA with respect to the drug program.
4. Provide immediate access by all HCA leadership to drug plans and priorities and enhance the ability to determine agency-wide priorities to the extent allowed by Federal and State mandates.
5. Help to integrate planning and budgeting decisions in the drug program at the agency level.
6. Apply an "agency" perspective and influence in dealing with the State on priority and funding issues.

VIII. OFFICE OF ALCOHOL AND DRUG ABUSE (continued)

Recommendations (continued)

Alternative III (continued)

Disadvantages

1. It places planning and evaluation at a point where a large and procedurally complex structure exists between it and service providers and contractors.
2. Citizen and provider involvement in the planning and evaluation processes would be difficult to design and implement.
3. Strong pressures (formal and informal) would exist to have the unit respond to HCA needs and priorities rather than those required by the total drug program.
4. Placement at agency (director or assistant director) level may not produce the necessary management time and attention by those who are already extraordinarily busy with "line" matters.
5. Isolation and "unilateral" decisions are also a danger in the highly centralized forms.

Alternative IV

The Interagency Ad Hoc Coordinating Committee

The CAO and participating agencies and departments have established a committee to coordinate County drug services. This body is discussed in the communications section of the report. Membership includes representatives from the CAO's office, Probation Department, Health Care Services, Pre-Trial Services Coordinator, and the Office of Criminal Justice Planning. The committee addresses operational problems, funding issues with the Federal and State government, general administration and coordination of the drug program and problems with contract negotiation and monitoring in community-based programs. Also the committee contributes to information exchange. The Drug Coordinating Committee's role might be expanded to include responsibility for drug program planning and evaluation. This would require designating the committee as a formal body and delegating the authority for producing a program plan and seeing that in-depth evaluations are completed. Also, the committee would be the interaction point among the program and various citizen and provider inputs in the planning process. Staff for the committee would be required. The pattern suggested Exhibit D would be appropriate. The head of the drug planning and evaluation unit would respond to the committee as a whole for completing broad assignments and to the committee's chairperson for more immediate concerns. Physical location of the unit is important and should be approached with some caution

VIII. OFFICE OF ALCOHOL AND DRUG ABUSE (continued)

Recommendations (continued)

Alternative IV

The Interagency Ad Hoc Coordinating Committee (continued)

to avoid negative perceptions on the part of "line" agencies. Given this requirement, a location not in any office of any member on the coordinating committee might be advisable. As expected, this alternative has pros and cons. Some of these are:

Advantages

1. It utilizes an interagency mechanism for the design and evaluation of a program which also is interagency in terms of service delivery.
2. It enhances coordination, understanding, and communications in the most important areas "what are the needs," "what should we do about it," and "what are our priorities."
3. Positive agreement among the involved agencies on the basics described in point 2 will minimize the need for operational coordination.
4. It tends to focus the planning process by having all actions relate to one committee through full-time staff.
5. It provides a forum for discussion of various agency priorities within the context of preparing a comprehensive plan and evaluating total program results.
6. It may generate more commitment to program administration since it would generate agreement on what everyone was trying to do.
7. The County Board could be assured that it would represent broad input in the planning process.

Disadvantages

1. Committee decisions tend to be more cumbersome and less efficient.
2. Decisions by interagency committee is a departure from normal practice and may be a less than satisfactory for some individuals.
3. Relating to committee membership will place demands on staff.
4. The "workability" of the alternative will probably rest heavily on the leadership of the committee and the planning and evaluation unit.

VIII. OFFICE OF ALCOHOL AND DRUG ABUSE (continued)

Recommendations (continued)

Recommendations

OPE's recommendation on which of the four alternatives is the most reasonable is influenced by our evaluation conclusions and more specifically by the following assumptions:

1. The present "conflicts" in role and base mission within OADA must be resolved.
2. Comprehensive program planning and evaluation needs to be established in the drug program.
3. A more formal determination of drug service needs should be undertaken.
4. County approaches to Federal and State agencies should be based on a firm definition of plans and priorities.

Given the above, alternative I and IV are the most reasonable and we recommend that the County Board adopt one of the two and direct the CAO and agencies involved to prepare an implementation plan and schedule. Both options separate planning and evaluation from conflicting functions; provide visibility and priority to these activities; take place in an environment which tends to be neutral and/or at least represents the least vested interest and can take a comprehensive approach to develop the plan.

Evaluation

Regardless of what alternative is selected by the County Board, program evaluation should be part of the total responsibility. Here we are not including the "monitoring" activities commonly referred to as evaluation. These are part of contract administration and as such would be the responsibility of HCA. There are a number of ways in which evaluations could be conducted. These include:

1. Planning and evaluation unit might contract with an outside third party.
2. OPE might conduct the evaluation under an internal agreement with the unit.
3. OPE might be given responsibility to conduct the evaluation by the County Board and then OPE contract with a third party.
4. The evaluation could be conducted by an outside group and OPE would review and approve the research design and work program.



VIII. OFFICE OF ALCOHOL AND DRUG ABUSE (continued)

Recommendations (continued)

Program Administration

The Health Care Agency would continue to be the chief instrument of administering the drug program. In this role, specific areas of responsibility would include:

1. Implementing the County Drug Plan in accordance with plan provisions and as it relates to the Health Care Agency.
2. Acting as the County's sole agent with the State and Federal agencies in liaison and funding matters.
3. Being responsible for the operation of the two County methadone programs.
4. Negotiating contracts with elements of the criminal justice system for County diversion slots stipulated in the plan.
5. Negotiating contracts with community drug programs and the State.
6. Participating in the planning process, developing evaluation criteria, and in assessing needs.
7. Insuring that programs comply with their administrative directions or contracts by monitoring and reviewing operations.
8. Carrying out required billing and collections procedures.

This evaluation does not call for an analysis of HCA's administrative units. Therefore, we do not comment on whether the above functions should be carried out within OADA or centralized within another existing unit in the Agency. This decision should take into account the need to provide a level of line accountability at the East Oakland and Eden Methadone Programs as long as they remain County operated.

Supportive Services

This report contains recommendations on supportive services. These cover a wide range of technical, logistic, financial, and medical services to drug contractors. Adoption and implementation of the recommendations will place the responsibility of building a total administrative support and program capacity when it belongs-on the contractor.

These budgets will need to be expanded to provide the support.

VIII. OFFICE OF ALCOHOL AND DRUG ABUSE (continued)

Relationship of Drugs and Alcohol

Alameda County combined central drug and alcohol functions following an analysis by the Health Agency. It should be noted that legislation requires the Alcohol Coordinator to be either the Director of Mental Health or the Health Agency Director (i.e., not the County Administrator). The concept of combining the functions of alcohol and drug and their central coordinator stems from the trend to consolidate funding and administration at the State and Federal level. Similarities among clients and the treatment modalities of the drug and alcohol programs also support coordination. Whether the combining of the Drug and Alcohol Coordinators has proved beneficial is something we have not addressed at this time.

We recognize that our recommendations will result in a redistribution of OADA duties and a separation of certain alcohol and drug planning and evaluation activities. An evaluation is underway in the Alcohol Program which probably will assess OADA from the perspective of alcohol planning, coordination, and administration. Although we accept that the present organizational combination of Drug and Alcohol in OADA should be taken into account, we believe it is valid to independently consider this report's conclusions and recommendations with respect to Drugs.

EXHIBIT B

1975-6 DRUG PROGRAM

<u>PROGRAM</u>	<u>COMPONENT</u>	<u>FUNDING SOURCE</u>	<u>AMOUNT</u>	<u>TOTAL</u>
Berkeley Free Clinic	Outreach	SB 714	\$ 32,250	
Bridge	Therapeutic Community	NIDA	\$392,156	
Center Point	Therapeutic Community	COUNTY	\$ 8,900	
Chysalis	Therapeutic Community	COUNTY	\$ 11,076	
C.D.C.	Outreach	SB 714	\$ 32,250	
		REVENUE SHARING	\$ 33,220	
		OTHER	\$ 32,626	\$ 98,096
County Schools	Prevention	COUNTY	\$106,046	
		REVENUE SHARING	\$141,281	\$247,327
C.U.R.A.	Detox	NIDA	\$125,000	
	Medical Backup	SB 714	\$ 47,047	
	Outpatient	NIDA	\$437,000	
		OTHER	\$109,250	
	Therapeutic Community	NIDA	\$120,000	
		OTHER	\$ 30,000	\$868,297
Delancey	Therapeutic Community	COUNTY	\$ 37,107	
Drug Awareness	Outreach	SB 714	\$ 55,725	
	EX-Addicts Employment	OCIP	\$133,334	\$189,059
Dublin Hotline	Outreach	SB 714	\$ 47,800	
		REVENUE SHARING	\$ 68,148	\$115,948
East Oakland	Methadone	SHORT-DOYLE	\$171,036	
Eden	Methadone	SB 714	\$210,216	
		NIDA	\$ 64,230	\$274,446
Group	Detox	SHORT-DOYLE	\$158,840	
		PATIENT FEES	\$ 6,000	
	Medical Backup	SHORT-DOYLE	\$ 49,883	
	Therapeutic Community	COUNTY	\$ 43,333	
		NIDA	\$ 95,942	\$353,998
Herrick	Methadone	SB 714	\$124,696	
		OTHER	\$ 55,304	\$180,000

1975-6 DRUG PROGRAM FUNDING

<u>PROGRAM</u>	<u>COMPONENT</u>	<u>FUNDING SOURCE</u>	<u>AMOUNT</u>	<u>TOTAL</u>
In-Touch	Outreach	SB 714 REVENUE SHARING	\$ 32,250 \$ 16,500	\$ 48,750
N.E.L.	Therapeutic Community Outreach	OCIP SB 714	\$ 89,016 \$ 39,600	\$128,616
Ombudsman	Outreach	SB 714	\$ 4,300	
Our Family	Therapeutic Community	COUNTY	\$ 14,491	
Project Eden	Therapeutic Community	COUNTY	\$ 47,024	
		NIDA	\$ 88,497	
		OCIP	\$ 22,222	
	Outpatient/Outreach	SB 714	\$ 32,250	
		REVENUE SHARING	\$ 23,791	
		OTHER	\$ 35,500	\$249,248
Second Chance	Outreach	SB 714	\$ 32,250	
Soul Site	Therapeutic Community	NIDA	\$125,000	
Teen Challenge	Therapeutic Community	COUNTY	\$ 8,900	
Walden House	Therapeutic Community	COUNTY	\$ 19,000	
West Oakland	Methadone Outreach	NIDA SB 714	\$303,733 \$ 32,250	\$335,983
Xanthos House	Outreach	SB 714 REVENUE SHARING	\$ 32,250 \$ 44,710	\$ 76,960

1) Chrysalis House has closed since the 1975-6 contract was signed and the funds will be distributed to other Therapeutic Communities

<u>REVENUE</u>			<u>EXPENDITURES</u>		
SB 714 (State Law)	\$ 679,621	(17%)	Detox	\$ 386,770	(10%)
Short-Doyle (State Law)	341,783	(9%)	Outpatient	546,250	(13%)
Revenue Sharing	327,650	(8%)	TC	1,149,706	(29%)
NIDA	1,602,881	(40%)	Methadone	929,215	(23%)
*County	574,085	(14%)	Prevention	247,327	(6%)
OCIP	200,572	(5%)	Employment	133,334	(3%)
Other	293,680	(7%)	Outreach	627,670	(16%)
TOTAL	\$4,020,272		TOTAL	\$4,020,272	

* includes matches to State/Feds

EXHIBIT C

1975-6 Office of Alcohol and Drug Abuse

	Monthly Salary	Man/Years		Cost of Drugs
		Alcohol	Drugs	
Assistant Agency Director (1)	\$2,530	.5	.5	\$1,265
Program Administrator III (1)	2,022	.5	.5	1,011
Administrator Services Assistant II (1)	1,480	.5	.5	740
Program Specialist II (2)	1,634	1.0	1.0	1,634
Physician III (1)	3,092	.5	.5	1,546
Secretary II (1)	1,026	.5	.5	513
Secretary I (2)	911	1.0	1.0	911
Statistical Clerk (1)	875	.5	.5	429
Program Specialist II (1)*	1,632	1.0	-	-
Statistician II (1)*	1,343	1.0	-	-
		7.0	5.0	\$ 8,049

* = temporary

	<u>x 12</u>
	\$ 96,588
20 percent Fringe Benefits -	+ 19,317
	\$115,905
minus 10 percent salary savings -	11,591
	\$104,314

EXHIBIT D

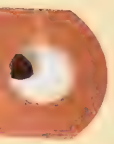
Proposed Drug System

<u>Department</u>	<u>Position</u>	<u>Man/Year</u>	<u>Monthly Salary</u>
CAO	Drug Coordinator	1.0	\$1,822*
CAO	A.S.A. II	1.0	1,480
CAO	Secretary I	1.0	911
HCS	Drug Abuse Specialist	1.0	1,634
HCS	Steno I or II	1.0	726
HCS - Billing	Account Clerk II	<u>1.0</u>	<u>862</u>
		6.0	7,435
			<u>x 12</u>
			89,220
			20 percent Fringe Benefits - <u>+ 17,844</u>
			107,064
A.C.D.A.	A.S.A. II	1.0	\$1,480
A.C.D.A.	Clerk II	<u>1.0</u>	<u>780</u>
		2.0	\$ 2,260
			<u>x 12</u>
			\$27,120
			20 percent Fringe Benefits - <u>+ 5,424</u>
			\$32,544

Total = \$125,637 minus 10 percent salary savings = \$125,637

Increase = \$21,323

* This is the salary paid to the Drug Coordinator in Santa Clara.



METHADONE PROGRAM
IMPACT

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7. East Oakland's Methadone Program.
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9. Concluding Chapter -- Recommendations and Discussion
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CAN METHADONE PROGRAMS IMPACT THE
PROBLEMS OF DRUG ADDICTION?

"The heroin epidemic only represents the top of the iceberg. To mistake heroin for the problem confronting us is naive."¹ The problem of drug addiction in America is a complex one. If there was a cure for drug addiction that was known today, the persons cured would still have so many problems that their susceptibility to relapse would be very great indeed.

"Just as it is absurd to treat the illness of children in the ghettos without striking at racism, poverty and malnutrition which are responsible for that illness, there is something absurd about planning national campaigns against addiction without recognizing and striking out against the social roots of addiction. If we grasp this fact then we must recognize that the ultimate solution to the problem of addiction is neither personal, moral, nor psychological but political, for it requires a fundamental transformation of our social order. In short, if we are committed to the elimination of addiction, we must be committed to the transformation of objective social reality so that men and women will no longer feel the need to nod their way through nor overdose their way out of life."²

With this understanding and commitment in mind we find ourselves called upon to try and find ways to help individuals who are already addicted to heroin. Do methadone programs help them with the problems that surround their addiction, or with the addiction itself, in any way? That is the subject of this impact evaluation.

REFERENCES

- 1 Henry L. Lennard, Leon J. Epstein, and Mitchell S. Rosenthal. "The Methadone Illusion." Science, Vol. 176, 1972, p. 881.
- 2 Ron Bayer. "The Radical Critique of Methadone Maintenance: A Radical Response." National Conference on Methadone Treatment IV. New York: National Association for the Prevention of Addiction to Narcotics, 1972, p.361.

REVIEW OF THE LITERATURE

A. Brief History of Methadone

In 1944, German scientists first synthesized methadone to meet wartime shortages of morphine and other opiate pain-killers.¹ In terms of its effects, methadone is similar to heroin.² However, unlike heroin, methadone's effects last much longer (up to about twenty-four to forty-eight hours as compared to about six hours for heroin). Also, methadone has the added advantage of being effective when taken orally. As a synthetic opiate, methadone abolishes the periodic withdrawal symptoms so often dreaded by the addict, and in high enough doses diminishes the reinforcing effects of heroin.³ These characteristics of the drug were influential in leading to its use in maintenance treatment of hard-core heroin addicts.

In the early 1960's, Vincent P. Dole and Marie Nyswander pioneered the use of methadone in treating New York addicts. "The addict was viewed as a patient in need of medical assistance for a kind of metabolic problem rather than as a weak-willed decadent unable to control his impulsive and antisocial (sociopathic) behavior."⁴ Emphasis was placed on social and individual rehabilitation, rather than on achievement of a drug free life. To quote Dole,⁵ "It does not strike me as relevant whether these patients ever get off methadone. Some may want to and that's fine. But what is relevant is that a treatment can be developed so that the addict can become a socially useful citizen, happy in himself and in society. That's much more important than whether he is on or off medication."

B. Causative Models of Addiction

In attempting to understand the causes of drug addiction, the following four principal models have been emphasized in the literature:

1. the medical model
2. the sociological model
3. the psychological model
4. the learning model

The medical model⁶ treats the human organism from a complex biological perspective. It suggests that the human body has a structural or biochemical flow that under proper conditions will cause it to seek and consume drugs. The medical model assumes a specific cause and effect response. This concept is difficult to test because other influencing factors cannot be controlled.

Sociologists emphasize the concept that individual behavior is profoundly influenced by social and cultural factors which may be etiological in the problem of addiction. This view has led to several valuable studies⁷ which indicate, for example, that one's attitude toward drugs is determined by the attitude of others within the social environment, and also that the initial introduction to drugs is influenced by the social milieu. The studies supporting the sociological model point to anomie, alienation, poverty and cultural deprivation as increasing the likelihood of drug abuse.

The psychological model⁸ emphasizes personality factors as contributing to addiction. Because the drug dependent individual rigidly adopts the use of drugs in response to life stresses, he or she is described as being sociopathic, neurotic, criminal, narcissistic and so forth.

The learning model⁹ emphasizes the role that conditioning plays in addiction and suggests that re-learning is an important aspect of treatment. Addicts are not diagnostically labelled, but their behavior is seen as repetitive during times of stress. That is, when stressed, the addict has learned that taking heroin can provide immediate relief of pain.

Although various models are used in an attempt to explain addiction, none have contributed to the development of a treatment modality which is successful for most addicts. Social problems like drug abuse are very complex and not suited to simple solutions. The roots of the drug problem lie deep in society.¹⁰ Certainly, racism, disenchantment, unemployment, poverty, hopelessness, and alienation are all factors which contribute to hard core drug addiction. Learning, no doubt, also plays an important role, as do early family experiences, particularly when they are stressful. The biological factors that may influence addiction have yet to be determined.

Current Controversy - Methadone Maintenance Versus Withdrawal

The controversy over whether methadone treatment should be a maintenance therapy or a time-limited treatment aimed at creating a drug free state is a current one. Furthermore, one's position regarding this controversy very often depends on how one views the causes of addiction. For example, Dole and Nyswander, believing in a metabolic basis for addiction, ascribe to a maintenance philosophy. Research¹¹ is now underway at the Drug Addiction Research Center in Palo Alto to discover whether or not addicts may suffer from a lack of Pituitary-Opioid-Peptide, a substance that acts like morphine and is found in the pituitary gland of several mammals, including man. It has been suggested that this peptide may be involved

in controlling pain and certain stress responses and in natural euphoria and well-being. If this possibility proves true, some people, if found to be deficient in this substance, may need to be maintained on some medication to relieve the deficiency.

Still others¹² believe that neither maintenance nor withdrawal are the key issues in defining a solution to the drug problem. They argue that using methadone on a large scale supports and reinforces a drug-oriented approach to the solution of social, economic, political, and personal problems.

It is not the purpose of this evaluation to argue about the causes of addiction. However, it is vital to realize that how one judges treatment and treatment effectiveness can be influenced by many factors, including how one views the causes of addiction. If one ascribes to the notion that drug addiction is a problem because people are weak-willed sociopaths, then the treatment of choice might be prison and its effectiveness defined as tenure behind bars. However, this would prove an unfortunate position since drugs are readily available in prison, and since prisons are costly ways to deal with drug addicted persons.

Although there are people who remain convinced that either withdrawal or maintenance should be the goal of methadone programs, the literature reveals that most persons assume a compromise position best described by Jerome Jaffee¹³ as follows: "At present we can say that some individuals may require long-term or even lifetime maintenance on methadone, while other individuals will be able to undergo eventual withdrawal after they have gone through successful rehabilitation."

C. Regulations Regarding Admission - Screening

Two governmental agencies, The Drug Enforcement Administration (DEA) and The Food and Drug Administration (FDA) regulate the use and administration of methadone. The client admission standards for methadone programs are as follows:

1. Voluntary participation.
2. A history of heroin or morphine dependence for at least two years prior to admission and a current dependence as evidenced by:
 - a. abstinence syndrome (rhinorrhea, lacrimation, pilo erection, and pupillary dilation)
3. Minimum age of eighteen, or sixteen with approval of the legal guardian or of the state if the person is a ward of the court.

Although admission criteria for methadone programs are regulated by several governmental agencies, it appears that adequate diagnostic and screening techniques for determining the extent of addiction or the tolerance to narcotics are not often used.¹⁴ Due to the low quality of street heroin, many users are not actually physiologically addicted. Consequently, the possibility exists that methadone programs risk turning heroin users, not heroin addicts, into methadone addicts.¹⁵ In a study¹⁶ of admissions to the National Institute of Mental Health Clinical Research Center at Lexington, Kentucky, 1971, out of one hundred consecutive admissions of opiate users, forty-three clients showed no actual, physical dependence when tested.

Careful screening becomes essential in providing methadone treatment to only those persons who are addicted at time of application for admission. A "dirty" urine (one that is positive for heroin) can be deceptive since some persons have been known to use heroin in order to gain admission to a methadone program and others have thought they were addicted when, in fact, they were not. The Addiction Research Center in Palo Alto uses Naloxone during admission screening. Naloxone is an opiate antagonist that causes withdrawal when taken by a heroin addict. Some clients have been denied admission on the basis of their non-addicted status. Use of Naloxone¹⁷ as part of a screening test could help eliminate inappropriate admissions to methadone programs.

D. Take Home Privileges and Dosage Levels

Governmental regulations over methadone programs allow for clients to earn take home privileges. That is, after ninety days on one program, the client may take home a one-day dose of methadone. After one hundred and eighty days of progress, the client may take home a two-day supply.

Take home privileges should be very carefully administered in any methadone program. For example, the Bureau of Narcotics and Dangerous Drugs has estimated that nationwide fifty percent of all methadone taken out of clinics in the form of take home doses ends up in illicit channels.¹⁸

Methadone can be lethal to non addicted persons, and especially to children. Furthermore, new addictions can be created through its illicit use. Methadone on the streets may also make it possible for some heroin addicts to "hold over" during dry periods; whereas, the unavailability of street methadone might have resulted in their seeking treatment during withdrawal. The primary advantages of getting methadone in a clinic setting are that the client necessarily comes in contact with staff who may be able to help with personal conflicts that foster addiction and that the clinic methadone is pure and not adulterated as street methadone may be.

A street habit of methadone costs much less than a heroin habit,¹⁹ and in at least some situations, persons applying to methadone programs suffer primarily from methadone addiction, rather than heroin addiction, though they may have been heroin addicts in the past. In a study by Weppner, Stephens and Conrad,²⁰ 37 percent of patients entering treatment at Lexington reported getting methadone from a friend who was in treatment and 44 percent said they received it from their usual heroin pusher. In another study,²¹ in which follow-up of 55 terminations from a low-dose maintenance program was conducted, 89 percent of the clients had relapsed to continuous drug use within six months. Of the 55 clients, 35 percent were abusing illicit methadone diverted from treatment programs.

Take home privileges in methadone programs are important therapeutically, since having to come to a treatment program seven days a week may in itself be cause for dropping out. However, the importance of carefully monitoring which clients get take home privileges cannot be overstated. "It has been demonstrated by prospective and retrospective studies that methadone treatment is medically safe, with minimal side effects and with no toxicity. However, methadone in treatment doses is toxic and potentially lethal when taken by non-tolerant individuals."²²

The risk of illicit methadone diversion increases at higher doses of methadone. "From the standpoint of the community and of our obligation to prevent diversion of methadone with its attendant dangers, the lowest effective dosage is clearly to be preferred....Addicts are veteran experimenters with drugs. Since we were able to demonstrate that low dosage suffices, the patient on high dosage will make the same discovery, and the excess will become available for sale or give-away"....²³ Furthermore, studies²⁴ have been completed which demonstrate that a dose of about 50 mg. is adequate in preventing withdrawal symptoms, and would replace 200 mg. of heroin, the equivalent of about \$100 daily habit (1974 prices). Several blind dose studies have been reported on by Wilmarth and Goldstein.²⁵ Results have not revealed any important differences in heroin use when methadone doses varied between 40 and 160 mg. The intensity of withdrawal is lessened, when clients receive lower doses of methadone. Since the severity of withdrawal symptoms depends on the degree of methadone dependence, at higher dosage levels, greater opiate dependency is created.

E. Methadone Maintenance Treatment Outcome and Detoxification from Methadone - Importance of Counseling

Studies²⁶⁻²⁸ on outcome for methadone clients have substantiated two major findings:

1. Clients who remain on methadone programs for a year or so have a significantly reduced involvement with the criminal justice system;
2. Clients who remain on methadone programs reduce their use of heroin.

One follow-up study²⁹ of 273 clients on the Santa Clara County Methadone and Rehabilitation Program showed that for clients who stayed in the program, heroin use declined, as did felony arrests. However, the use of other drugs continued at a low but consistent rate. Conger,³⁰ in evaluating the San Francisco Maintenance Research Program, pointed out that the probability of any addict spending one year in remission from heroin use while on methadone is less than 10 percent.

The success rates for clients who detox from methadone programs have not been very great. Whether clients detox voluntarily after a long period of time on a methadone program or whether they detox prior to program dismissal or suspension, outcome in terms of drug use or involvement with criminal justice is not very hopeful. For example, in one study³¹ of 124 discharges from a methadone program, only 11 or 8 percent were able to refrain from drug use once detoxed from methadone maintenance. Wilmarth and Goldstein³² pointed out that all the data on withdrawal seem to show that abstinence is difficult to attain in more than a fraction of patients who try and may have to do with the techniques of withdrawal rather than with a fundamental inability of clients to function without narcotics. They suggest that low doses of methadone, from 10 mg. to 30 mg., may cause discomfort of the withdrawal type, as though relief from withdrawal occurred only for a part of the day.

The importance of emotional support for the client in the detoxification phase of treatment has been stressed in the literature. As Chappel and Senay³³ stated, "It is our hypothesis that the most important factor in successfully completing withdrawal from methadone is the development of stable sources of interpersonal support. The individual must develop an ability to use people rather than chemicals in times of stress. The developments take time and require sources of effective supportive therapy."

Counseling is considered important not only for clients trying to reach a drug free state, but also for those clients who may be new to a program or ambivalent about giving up drugs. Fort³⁴ pointed out, "All people coming for methadone do have other problems. To say that they need no other services is to simply ignore the reality and to be irresponsible.... Methadone at best will give symptomatic relief of some of them or obscure many of them but it will certainly not deal with the social and psychological causes and effects of long-term heroin addiction."

Summary

The areas explored in this literature review have included the following:

1. brief history of methadone
2. causes of addiction/goals of treatment:
maintenance versus withdrawal
3. screening for admissions
4. take home privileges
5. dosage levels
6. outcome studies
7. importance of counseling

All of these factors will be highlighted as each methadone program is reviewed and its impact described. An understanding of the programs requires an understanding of some of the problems inherent in providing methadone treatment to addicts.

To expect methadone programs, or any other form of drug treatment, to solve the addiction crisis in our country is unrealistic. If heroin were unavailable, the human beings who now use heroin to relieve their pain would probably find other substances for abuse or resort to other antisocial behavior. Until the social problems in our country are alleviated, the decay that is expressed through addiction and through crime will continue to be with us all.

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HERRICK METHADONE TREATMENT PROGRAM (CONTRACT) - IMPACT

Herrick's treatment program began in May, 1971. Since the program opened, about four hundred clients have been admitted. At the present time, Herrick's program has one hundred authorized, budgeted treatment slots. In October 1975, all of the slots were filled.

The program is located within Herrick Hospital, 2001 Dwight Way, Berkeley. It occupies several offices adjacent to the Psychiatric Outpatient Department of the hospital. In addition, the program rents a two-story house on Blake Street, just a block away from the hospital. All dispensing is done on the hospital grounds, but most of the therapy, especially group counselling, takes place at the house.

The director of Herrick's program is Walter Byrd. Herrick Hospital's administration recently recognized Mr. Byrd as the official director of the Methadone Program. Since the hospital generally reserves the title of director for medical personnel, this decision represents their confidence in Mr. Byrd's particular administrative and clinical abilities.

Group therapy is mandatory at Herrick's program, except for clients who need one-to-one counselling. This is determined by a psychiatric evaluation completed during intake and by a person's behavior in the group environment. The groups are divided in terms of their focus. For example, the program has a beginning group and a group for persons in the detoxification phase, as well as intermediate groups. According to the director, the major goal of treatment is to help people stop using illicit chemicals and other self-destructive drugs. Continued use of heroin, after warnings are given and intensive counselling has been established, results in dismissal. Also, any violence on the premises, and/or selling or using drugs on the premises, results in the same action.

At Herrick's program, a client must be clean for 90 days (no dirty urines), must be attending therapy, must be working, in school, taking care of a household, or in training to earn a take-home privilege. Once a take-home privilege is earned, two dirty urines within 90 days causes the privilege to be revoked. A client must then remain clean for 90 days from the last date of the dirty urine before he can earn one take-home privilege again. A maximum of two take-home privileges can be earned on this program. Rules are consistently enforced at Herrick. Dispensing hours are from 6 a.m. to 8:30 a.m. If a client appears at 8:35 for his methadone without special arrangements having been made in advance, he/she will not receive methadone for that day.

Table 1 (on the next page) shows the number of records reviewed by the evaluation team at Herrick's program, the number of clients interviewed in each category, and the percent of the clients represented in each category.

TABLE 1

<u>Client Categories</u>	<u>Number of Records Reviewed</u>	<u>Number of Clients Interviewed</u>	<u>Number of Herrick's Clients That Fit Each Category</u>	<u>Percentage of Total Represented in Record Review</u>
Clients enrolled Less than 1 year	10	10	N=65 **	15.4%*
Clients enrolled More than 1 year, but less than 2½ years	10	10	N=19 **	52.6%*
Clients enrolled More than 2½ years	10	10	N=19 **	52.6%*
Clients who left the program after being enrolled 4 months or less	10	0	N=35	28.5
Clients who successfully detoxed from the program	10	6	N=26	38.5
Total	50	36		

* Overall, 29.1% of Herrick's active clients had their records reviewed by the drug evaluation team.

** Herrick's total active clients (N=103) exceed the one hundred budgeted treatment slots. This is possible because programs are allowed to have 10% more clients enrolled than their number of funded treatment slots.

RESULTS OF RECORD REVIEW--ADEQUACY OF RECORD KEEPING

For the most part, Herrick's records are very well organized. Over the last several years, all clinical entries have been recorded. Records are consistently in order, with different forms appearing in the same place in each record. A special form allows for the group therapist to briefly record progress notes. Staff persons are careful to lock up records at the end of each day, and members of the evaluation team were carefully instructed to return all records to the director as soon as possible.

For clients who had been in the program more than two years, a justification for their continued program enrollment, as required by state law, was found in each of the ten charts reviewed in this category. It was clear that personal attention had been given to each client by a psychiatrist on the staff prior to writing the two-year justification. Moreover, since therapy is required by this program, progress notes demonstrated the process of the individual's growth, or lack of growth, since program entry.

All information for any client, i.e.: medical, clinical, historical, can be found in one record. This enables all staff to review all material for any client without having to pull out several records from different locations within the program.

In summary, Herrick's records are above average in almost all respects. Maintaining all client information in one record was unique to this program.

Records were weak in two areas:

1. An in-depth psycho-social history was often lacking at time of program admission, even though drug taking history and treatment failures were documented.
2. Medical follow-up was hard to evaluate since clients on this program are often referred elsewhere for medical checkups and problems.

CLIENT CHARACTERISTICS - Table 2

Table 2 shows the characteristics of the clients sampled from Herrick's program. As can be seen, clients entering Herrick's program are usually in their late twenties. More than half the current population is male and about half is black.

TABLE 2

Client Characteristics--Herrick Program
N=50

<u>Client Categories</u>	<u>Age</u> (When entered treatment) Mean	<u>Education</u> Mean	<u>Male</u>	<u>Black</u>	<u>Married</u> (currently married or separated)
Left Program after 4 months or less (N=10) (mean = 3.0 months)	27.6 SD* = 3.5	11.2 SD = 1.3	70%	40%	60%
Enrolled under 1 year (N=10) (mean = 5.3 months)	26.5 SD = 3.6	13.4 SD = 2.4	70%	50%	20%
Enrolled more than 1 year (N=10) Less than 2½ years. (mean = 16.1 months)	28.3 SD = 4.7	12.3 SD = 1.4	70%	40%	70%
Enrolled more than 2½ years (N=10) (mean = 43.8 months)	38.6 SD = 8.5	12.7 SD = 1.3	50%	40%	80%
Successful Detox (N=10) (mean = 15.3 months)	27.8 SD = 5.9	13.2 SD = 2.3	70%	50%	50%

* SD = Standard Deviation.

It is interesting to note that clients who remain for the shortest period of time (leave the program) tend to be less well educated. The highest educational level is reached by clients who have successfully detoxed from the program and by those who are enrolled under one year. It is also interesting to note that clients who have remained on the program the longest were much older when they entered treatment.

Marital status and race were further broken down as follows:

<u>Clients Categories</u>	<u>Married</u>	<u>Never Married</u>	<u>Separated</u>	<u>Divorced</u>
Left Program after 4 months or less (mean = 3.0 months)	4	3	2	1
Enrolled under 1 year (mean = 5.3 months)	1	6	1	2
Enrolled more than 1 year, Less than 2½ years (mean = 16.1 months)	7	3	0	0
Enrolled more than 2½ years (mean = 43.8 months)	7	1	1	1
Successful Detox (mean = 15.3 months)	2	3	3	2
TOTAL	21	16	7	6 = 50

<u>Client Categories</u>	<u>Black</u>	<u>White</u>	<u>Chicano</u>	<u>Asian</u>	<u>Other</u>
Left Program after 4 months or less (mean = 3.0 months)	4	6	0	0	0
Enrolled under 1 year (mean = 5.3 months)	5	5	0	0	0
Enrolled more than 1 year, Less than 2½ years (mean = 16.1 months)	4	5	0	0	1
Enrolled more than 2½ years (mean = 43.8 months)	4	5	1	0	0
Successful Detox (mean=15.3 months)	5	3	1	0	1
TOTAL	22	24	2	0	2 = 50

INTAKE INFORMATION - Table 3

Table 3 (on the next page) shows information obtained during the program's intake process for the clients sampled. As can be seen in column II, clients entering Herrick's program averaged more than the two previous, nonmethadone treatment experiences required by law. Clients who successfully detoxed, as well as those who have remained in the program the longest, were more often self-referred (column III) and were less often on probation (column IV) at the time of admission. Also, longer-term clients (2½ years or more) evidenced the longest, continuous run on heroin (column VI) at some time prior to entering treatment and all of them had some criminal involvement for nondrug related crimes (column IX). Longer-term clients also had more years of addiction than did clients in other categories (column V). Perhaps these factors are related to a need for longer methadone treatment.

Cost of habit (column VII) is harder to evaluate. Those in the 2½ year category with the longest run were paying less per day for their habit than were clients in the other categories, except for persons who left the program. The reason for this is unknown. It may be that their connections were better or that the cost of drugs was less during the time they were purchasing them.

Referral source was further broken down as follows:

Client Categories	Self-Referred*	Referred by Criminal Justice	Referred by Other Treatment Programs	Referred by Family	Referred by Friends	Referred by Private Doctor
Left Program after 4 months or less (mean = 3.0 mos.)	6	2	2	0	0	0
Enrolled under 1 year (mean = 5.3 mos.)	6	2	0	0	2	0
Enrolled more than 1 year, Less than 2½ years (mean = 16.1 mos.)	5	2	2	1	0	0
Enrolled more than 2½ years (mean = 43.8 mos.)	7	2	0	0	0	1
Successful Detox (mean = 15.3 mos.)	8	0	2	0	0	0
TOTAL	32	8	6	1	2	1 = 50

*Most clients are self-referred, but this was especially true for clients who successfully detoxed.

TABLE 3

INTAKE INFORMATION--HERRICK PROGRAM
N=50

Client Categories	I Number of Previous Methadone Treatments Mean	II Number of Other Drug Treatments Mean	III Self- Referred	IV On Probation or Parole	V Number of Years Addicted Mean	VI Longest Run On Herion-- In Months Mean	VII Cost of Habit Per Day Mean	VIII History of Criminal Involvement For Drugs	IX History of Criminal In- volvement for Other Crimes
Left Program after 4 months or less (N=10) (mean = 3.0 months)	.30 SD = .48	5.8 SD = 3.9	60%	70%	7.0 SD = 3.7	17.3	\$ 61.66	40%	80%
Enrolled under 1 year (N=10) (mean = 5.3 months)	.40 SD* = .70	3.5 SD = 2.3	60%	50%	5.8 SD = 2.5	12.4	\$ 88.00	60%	50%
Enrolled more than 1 year, less than 2½ years (N=10) (mean = 16.1 months)	1.0 SD = 1.2	2.6 SD = 1.9	50%	50%	9.7 SD = 4.8	20.8	\$114.00	50%	90%
Enrolled more than 2½ years (N=10) (mean = 43.8 months)	.20 SD = .42	3.7 SD = 2.7	70%	20%	10.1 SD = 6.4	43.7	\$ 62.00	70%	100%
Successful Detox (N=10) (mean = 15.3 months)	.40 SD = .52	4.8 SD = 2.7	80%	30%	8.7 SD = 4.8	23.4	\$ 90.28	60%	50%

* SD = Standard Deviation.



It should be noted that when one considers the 50 clients as a whole, 56% of them had some criminal history for drug related offenses and 74% had criminal histories for other crimes. Most often other crimes involved theft, forgery, or assault, usually combined with robbery. Also, when work histories were studied, as a group, Herrick's sample showed that they had worked sporadically. However, clients who were successful at detoxing from methadone had work histories which showed they worked steadily, but not always full time, prior to program entry.

PROGRAM DATA - Table 4

As might be predicted from studying the manner in which the program is run, Table 4 (on the next page) shows that clients who remain in Herrick's program remain clean longer as their tenure in the program increases (column I). Also, methadone dosage levels decrease as time in the program increases (column II). The last quarterly report that Herrick sent to the State showed of 2,118 urine tests taken, only 10% of the tests or 212 were positive for opiates. Furthermore, only a little over 1% of the tests showed an absence of methadone in the urine. Since some of Herrick's clients were on very low doses of methadone, especially clients who were in the detoxification phase of treatment, this small percentage is to be expected.

In regard to counseling provided (columns IV and V), a word of caution in interpreting the data is needed because in the early stages of Herrick's program, group and one-to-one entries were not as consistently recorded as they are now. The average number of sessions for clients who have been in the program over 2½ years and for clients who successfully detoxed is considered by the evaluators to be a gross underestimate. The last quarterly report that Herrick sent to the State showed that 79 clients received 446 one-to-one counseling sessions over the three-month period, or about two sessions per client each month. A total of 59 clients received 51 group sessions weekly. Since there were only 103 clients enrolled in the program, it is likely that some clients were receiving both one-to-one and group counseling.

As column VI shows, methadone is not taken home very often by Herrick's clients. There is an increase in take homes granted to clients who have remained in the program longer and who have remained clean.

No one was arrested for drug related offenses (column VIII) while on Herrick's program except in the category of "left the program." However, arrests for nondrug related offenses (column IX) were somewhat more frequent, especially for newer clients.

INTERVIEWING DATA - Table 5

As can be seen from Table 5 (on page 9), a large percentage of clients are using marijuana and alcohol (columns I and V), with only a small number using other drugs (columns II, III, IV, VI). Since this may be true of persons in our society generally, this finding is not very alarming. However, of the 10 persons who successfully detoxed from methadone, four had a drinking problem that was considered moderate to severe. Of the clients who had been on the program over 2½ years, 40% (N=4) had a drinking problem. It may be that giving up heroin, as well as methadone, is significantly related to some people's taking up alcohol.

Table 4 relates to information obtained relative to the program experience of the client. The information was gathered by members of the evaluation team by searching through the clients' records.

TABLE 4

METHADONE PROGRAM RELATED INFORMATION

N=50

Client Categories	I Since Last Dirty Urine Results, Months Clean Mean	II Current Methadone Dose Mean	III Since Program Entry, dirty Urines for Barbs or Amphetamines? Mean	IV Number of One-to-One Sessions Mean	V Number of Group Sessions Mean	VI Number of Times Per Week--Take Home of Methadone Mean	VII Currently Employed?	VIII Arrested for Drug Offenses While on Program?	IX Arrested for Other Crimes While on Program?
Left Program after 4 months or less (N=10) (mean = 3.0 months)	NA	53.0 SD = 10.59	60%	9.5 SD = 8.8	3.9 SD = 3.1	0	Unknown	100%	10%
Enrolled under 1 year (N=10) (mean = 5.3 months)	1.8 **SD = 1.4	39.5 SD = 11.16	40%	13.3 SD = 12.7	8.1 SD = 10.7	.60 SD = .70	50%	0	20%
Enrolled more than 1 year, less than 2½ years (N=10) (mean 16.1 months)	Mean = 5.2 SD = 5.6	37.5 SD = 16.87	80%	26.8 SD = 12.3	31.6 SD = 20.2	1.1 SD = .99	70%	0	20%
Enrolled more than 2½ years (N=10) (mean = 43.8 months)	Mean = 15.0 SD = 11.9	31.0 SD = 13.29	50%	19.2 SD = 14.2	26.9 SD = 29.4	1.8 SD = .42	50%	0	0
Successful Detox (N=10) (mean = 15.3 months)	Mean = 6.7* SD = 6.0	NA	60%	11.1 SD = 15.5	18.8 SD = 15.2	1.5 SD = .85	100%	0	0

* Successful Detox - these clients were clean an average of 6.7 months before leaving the program. Six of them were interviewed and had been remaining clean since program discharge.

** SD = Standard Deviation.

Table 5 relates to information obtained from clients by the evaluators during interview sessions, October, 1975.

TABLE 5
INTERVIEW DATA--HERRICK CLIENTS
N=36

Client Categories	I Used Marijuana in Last Month	II Used LSD in Last Month	III Used Barbs in Last Month	IV Used Amphetamines in Last Month	V Used Alcohol in Last Month	VI Used Other Non-prescribed Drugs in Last Month	VII Should Clients Participate in Decision- making of Program?	VIII Are You Satisfied With the Program's Hours?	IX Do You Believe Methadone is Safe?
Left Program after 4 months or less (mean = 3.0 months)	(No clients who had left program were interviewed)								
Enrolled under 1 year (N=10) (mean = 5.3 months)	60%	0	0	10%	80%	20%	80%	50%	70%
Enrolled more than 1 year, less than 2½ years (N=10) (mean = 16.1 months)	90%	0	0	10%	40%	10%	60%	50%	80%
Enrolled more than 2½ years (N=10) (mean 43.8 months)	60%	0	20	0	80%	10%	60%	60%	80%
Successful Detox (N=6) (mean 15.3 months)	80%	0	0	0	80%	0	70%	100%	80%

A large percentage of clients felt they should participate in the decision-making processes at Herrick (column VII), and, in fact, the program allows for this through the Patient's Council. Satisfaction with the program's hours (column VIII) increases slightly as tenure in the program increases, and all clients who had been successful in detoxing believed Herrick's early morning dispensing hours helped them to get motivated to do something with the rest of their day.

Summary of Other Interviewing Data

The current physical health of clients interviewed ranged from good to very good. Prior to program entry, physical health was generally considered only fair. At least half of the clients expressed the belief that taking methadone interfered with their sexual functioning, especially at higher doses. Despite this, almost all clients interviewed believed that being on the methadone program had helped them feel better about themselves. Relationships with family members went from fair or poor to good, as did relationships with friends. Clients attributed these changes to the program.

Clients rated the counseling services at Herrick as good. All of the clients who had successfully detoxed believed counseling should be required by the program, as did 7 of the 10 persons in the program under one year. However, for the two other categories of clients interviewed, only 40% (N=8) believed counseling should be mandatory. It should be remembered that Herrick does require clients to receive counseling as part of its program.

Conjecture--Herrick Has Two Major Types of Clients

There is a possibility that Herrick's program has two distinct types of clients--those aiming for detoxification and those aiming for maintenance, with detoxification a more remote possibility. The clients who had been on the program for over 2½ years (average 3 years and 8 months) had longer addiction histories and greater criminal involvement prior to program entry. They were also less likely to consider counseling important. Only about half of them were working at the time of the evaluation interview. Just the same, they were remaining relatively clean and none had been arrested since admission. Perhaps these clients, who seem to be doing well on the program, would be more reluctant to leave the program. The other group (enrolled under 1 year) is younger upon entering treatment, considers counseling a key factor in rehabilitation, is better educated, and has a criminal history pattern that more resembles the successful detox group. In fact, these clients resemble the successful detox group more than any of the other client categories. Perhaps they aim for detoxification as they enter the program. Unfortunately, this question was not systematically asked by the evaluators.

Since its doors opened, Herrick has successfully detoxed 26 clients. Actually, more than 26 clients have detoxed from the program, but these 26 people are believed to be functioning well and to be free of illicit chemicals.

Selected Significant Correlations (Pearson r's)

Pearson r's were computed for the 30 clients who continued active on Herrick's program. Successfully detoxed persons and persons who left the program were left out of this analysis. The evaluators wanted to get an up-to-date picture of the relationships that might exist between variables for clients currently enrolled. Programs change over time, as do the clients enrolled in them, and for these reasons clients no longer on the program were excluded from the correlational analysis. It would lengthen this report considerably to cite all the significant correlations found and discuss their meaning. Therefore, only a few have been selected for presentation.

In Herrick's program there was a significant relationship found for remaining clean and receiving a lower dose of methadone ($r=.4420$, $p<.007$). Clients on higher doses of methadone were less likely to be taking methadone home ($r=.6770$, $p<.001$). Moreover, the client taking methadone home had been in the program longer ($r=.5485$, $p<.001$), and clients who had been in the program longer were more likely to be clean ($r=.5735$, $p<.001$). These findings are what one would expect from observing the manner in which the program is managed. The risk of methadone diversion is lessened by the policies which are consistently enforced at Herrick.

Number of group or one-to-one sessions received did not correlate significantly with remaining clean, methadone dosage levels, or other progress while on the program. However, since the number of sessions attended is probably an underestimate for clients who had been in the program 24 years or more, this finding must be taken with reservation. Also, quantity is not the same as quality of counseling. Almost all of the clients interviewed said the counseling services at Herrick were good.

Why Did Clients Leave the Program After Being Enrolled Four Months or Less?

The following is a summary of the information obtained from the record:

- 2 clients were discharged by the program for not following through with program requirements.
- 1 violated parole and was sent back to prison by the parole officer.
- 1 left because he did not like the effects of methadone.
- 1 client said he did not wish to stop using heroin completely and did not want to attend groups. He detoxed AMA (against medical advice).
- 1 client was dismissed by the program for continued use of heroin.
- 1 was discharged to another type of treatment program.

Why Did Clients Leave the Program After Being Enrolled Four Months or Less (cont'd.)

1 was discharged AMA after being warned of possible program dismissal.

1 detoxed AMA--no reason given in record.

1 discharged--no reason given in record.
10

What Were Successful Detox Persons Doing Now?

Six persons were interviewed who had successfully completed Herrick's program. All were fully employed, free of criminal involvement, and said they were remaining free of opiates. One person had been clean for three years, one for four years. The shortest period of time free of opiates was stated to be eight months and this occurred for the newest discharge of the successful group. All of the successfully detoxed clients interviewed were involved in meaningful interpersonal relationships.

As far as could be determined from the records of the other four clients not interviewed, they should all be doing well at this time. Staff have periodic contact with them, either directly or indirectly through friends.

Summary of the Impact of Herrick's Methadone Program

Clients are remaining drug free or reducing their drug use as a function of remaining on the program. Also, arrests seem to be decreasing, and personal relationships seem to be improving. Clients report feeling better about themselves, as well.

Herrick's program is accomplishing a great deal. The staff are dedicated, well-organized, and consistent in their behavior. As evaluators visiting the program for 12 working days, we had the opportunity to observe methadone dispensing and other client-oriented activities. There is a spirit of commitment and conscientiousness found in this program that is unequalled in any of the others. Results obtained substantiate the worth of the program.

We would recommend that Herrick staff obtain more complete psycho-social data during intake and substantiate medical follow-up more clearly in their records. Aside from these two suggestions, the program was found to be functioning in a superior way.

Recommendations:

1. Develop and implement an in-depth client psychosocial history form to be completed during intake.
2. Substantiate medical follow-up more clearly in the client records.



CLIENTS' COMMENTS

CLIENTS' COMMENTS

At the end of each interview, clients were offered the opportunity to add any comments about their experiences with Methadone or with the Methadone Program. These comments are included in the report to give the reader a small glimpse of the clients' feelings. It should be mentioned that there were many opportunities during the interview for comments to be made by the client. For example, Item 37 on the Client Data Form (see Appendix) yielded many personal responses. Some of the more common ones were: "Methadone saved my life," "helped me function more normally," "gave me time to think," "gave me a chance to keep my personal relationships," "no need to hustle."

For the most part, the clients at Herrick's program have confidence in the staff. Although not all comments are favorable, clients trusted the counselors and program director well enough to talk with us and to be at least fairly honest and open. We want to take this opportunity to thank those clients who gave of their free time to share their very personal histories and thoughts with us, and to thank the staff at Herrick who went out of their way to encourage client participation in the study.

CLIENTS' COMMENTS

Clients in the Program Less than One Year (N=10)

1. The program really saved my life ...Heroin broke up my personal life... The purpose of this program is to get people off Methadone and you can't do that without counseling.
2. Methadone has helped my moodiness and I can sleep better now.
3. The staff seems to know something about drug abuse. Compared to other programs, this is the best. The staff does have a punitive attitude, but I'm not making any value judgment on that.
4. I feel the program is helpful but I haven't been on it long.
5. In large doses, Methadone causes constipation and sleepiness - also, weight gain, a nervous type of eating. Coming down off Methadone, you have to be very stable because of the anxiety and short-temper. You have to be aware of yourself.
6. The staff here seems helpful and sincere. Yet I feel frustrated a lot not knowing my dose and it's so hard to get take homes..It's demoralizing giving urines but I don't know how you'd get around that.
7. I object to coming to groups. You can't get a take home without it. You get an automatic dirty if you don't give a urine. After three days, if you don't give a urine, they won't give you Methadone. If you miss coming four days out of a month, you get a fifteen day detox and kicking Methadone is harder than kicking heroin. I'd have to shoot heroin to keep from getting sick...Methadone makes be crave beer every day.
8. For someone who has used drugs for a long time, Methadone is more likely to help them. Most of the hard core addicts at (another type or program) left the program.

(Two Clients had no comments)

Clients in the Program More Than One Year
But Less than Two and One-Half Years (N=10)

1. Methadone holds me and if I use Heroin, I can't get high as much. I missed getting Methadone for two days and my ears were ringing. I had hot and cold sweats...I lost a job when they found out I was on Methadone.
2. It (Metadone) helps cause you're working but it's still a bummer cause you're hooked on something else. Maybe you're killing yourself on Methadone and don't even know it. The staff are kind of too strict in their rules here. Some people get so uptight they fix. There's a lot of pressure to talk in groups. All the counselors should be ex-addicts.
3. This is the best program I've been in...a lot of personal attention from staff. They know what's going on.
4. Urine tests aren't always reliable. They ought to have an alternative lab...There are too few women on the staff so women can't come back during the day to urinate...They need more child care for people who come to groups with their kids--maybe from the patients themselves. The staff here need to give a little more play to the patients.
5. This program needs a job developer...Methadone is like insulin--I need it to stay off the streets.
6. _____ (Another Methadone program) types are starting to get into this program--a lot of fuck-ups trying to deal dope. I used to use drugs to avoid family problems - counseling helped me deal with them.
7. The only thing I don't like about this program is that they keep people on for over four months that don't stay clean--No room for new people who really want to try.
8. Methadone saved my life. I feel good about this program.
9. If I'm late, no Methadone. They ought to make exceptions. Anytime anybody on this program has deserved special privileges, he has gotten them.
10. They should have dispensing hours from 5:00 to 6:00 p.m. also... I came here to save my life. Walter and all the staff take a personal interest in us...The greatest need people have here is for counseling.

Clients in Program Over Two and One-Half Years (N=10)

1. Methadone is a life-saving drug.
2. I'm detoxing now. I've been on long enough and I'm not chipping.
3. Methadone has given me a chance to get a taste of life and get some possessions. It's a strong drug and you get sick if you try to do without it...they make you work for your take homes...they really have it together.
4. Methadone isn't good for me but it's the best thing for now. I'm getting my life straightened out.
5. It's (Methadone) very strong. I get hot and cold chills when I try to go without it.
6. It takes time to change your life style. People shouldn't get kicked off for dirty urines. They (staff) ought to give more personal attention to each person.
7. The attitude of a counselor towards a dope addict is very condescending... I'm very conscious of being hooked on Methadone.

(Three Clients offered no comment).

Successful Program Completers (N=6)

(Four of the Ten Could Not be Located for the Interview)

1. Information about Methadone should be given out to people. People should be examined regularly and given blood tests...Coming from the middle-class made it easier for me to stay clean and make it. That fact should be discussed more in groups. They need a woman counselor who's an ex-junkie on the staff. You know, kicking (Heroin) is like getting your ego shattered..Counseling is important.
2. Working helped me a whole lot to stay off drugs, but groups were the most important thing to me.
3. I still come to the program occasionally...This program tends to weed out less serious people. The staff is concerned...Your body wakes up when you detox from Methadone.
4. Methadone lessens your receptiveness--you are less aware of yourself and others...I'm very positive about this program.
5. A client on Methadone should be maintained no longer than a two-year period. The drug (Methadone) is too addicting; you're kidding yourself after two years.

(One Client made no comments).

WEST OAKLAND METHADONE TREATMENT PROGRAM (CONTRACT) - IMPACT

West Oakland's methadone treatment program began in August, 1971. Since the program opened, about 480 clients have been admitted. At the present time, West Oakland's program has 300 authorized slots, with 200 of them being funded. In October, 1975, 185 of the slots were filled.

The program is located in a large, older building in the heart of West Oakland at 688 7th Street. It is next door to a liquor store, and clients hang out both in front of the program and the adjacent liquor store. This behavior is not unique to the program, since clusters of people on street corners are frequently seen in West Oakland.

The director of West Oakland's program is Elmer Franklin. Mr. Franklin comes from New York City where he worked in a methadone program in Harlem, and had only been with West Oakland for several months prior to this evaluation. Mr. Franklin reports to the overall program director, Dr. Isaac Slaughter. This creates some administrative confusion relative to the lines of authority and levels of responsibility.

West Oakland has perhaps one of the hardest populations to treat of any methadone program in the area. Clients have long histories of hard-core drug abuse and of criminal activity. They are, for the most part, not well educated in the formal sense and have limited employment histories. The clients may tend to be suspicious of treatment, especially of group counseling, since they have often been forced into groups while incarcerated. Very little counseling, whether group or individual, was observed to be taking place when the drug team visited West Oakland. Observations are based on case record review, clients' comments, and being in the environment for seven working days. Moreover, some members of the staff were observed to spend inordinate amounts of time chatting, reading the paper, or watching television. During the dispensing hours of 7 a.m. to 2 p.m., many clients were observed to gather around the dispensing station, but very few staff persons were seen. It should be mentioned that West Oakland also dispenses from 4 p.m. to 5 p.m. for persons unable to attend the earlier hours.

According to the overall program director, the major goal of treatment is to help clients reduce their use of drugs and to improve their self-images.

Rules are inconsistently followed by the staff of this program in terms of granting take home privileges and suspending clients for failure to follow through with various stated program requirements. This observation is based primarily on review of client records and, to some extent, client comments. One client may have a take home privilege revoked; whereas another client may not, even though their behavior is very similar. This point will be further clarified under the record review section of this report.

Table 1 on the next page shows the number of records reviewed by the evaluation team at West Oakland's program, the number of clients interviewed in each category, and the percent of clients represented in each category.

TABLE 1

Client Categories	Number of Records Reviewed	Number of Clients Interviewed	Number of W. Oakland's Clients that fit each Category	Percentage of Total Represented in Record Review
Clients enrolled less than 1 year	10	3	N=52	19.2%*
Clients enrolled more than 1 year, but less than 2½ years	10	6	N=37	27%*
Clients enrolled more than 2½ years	10	4	N=96	10.4%*
Clients who left program after being enrolled 4 months or less	10	0	N=10	100%
Clients who successfully detoxed from the program	10	1	N=17	58.8%
TOTAL	50	14		

* Overall, 16.2% of West Oakland's 185 active clients had their records reviewed by the drug evaluation team.

RESULTS OF RECORD REVIEW--ADEQUACY OF RECORDKEEPING

There are many problems with West Oakland's system of recordkeeping and with the program's service delivery function as evidenced by the records:

1. Nurses and counselors record the results of the urine tests in two separate charts for each client. One set is kept at the nurses' station; the other is located in the front, left-hand section of the counseling record. This in itself would not be a problem, however, in looking over both sets of records, information did not agree on urine results. It was rare to find two sets of data on the same urine results for one client that were identical. Because of this, the evaluation team, for the most part, only used the urine results as recorded by nurses, though both sets were checked for reliability in all 50 records reviewed.

Results of Record Review--Adequacy of Recordkeeping (cont'd.)

2. Two-year justifications, as required by law for clients who are continuing on methadone, were not found in all 10 charts reviewed in this category. Moreover, when a justification did appear, its appropriateness would depend on one's treatment philosophy. For example:

" _____ continues to use heroin while being maintained on methadone and readily admits so. _____ does not complain to the M.D. when _____ is in distress, but fixes (heroin). Inability to discontinue using heroin constitutes justification for continued maintenance beyond 2 years."

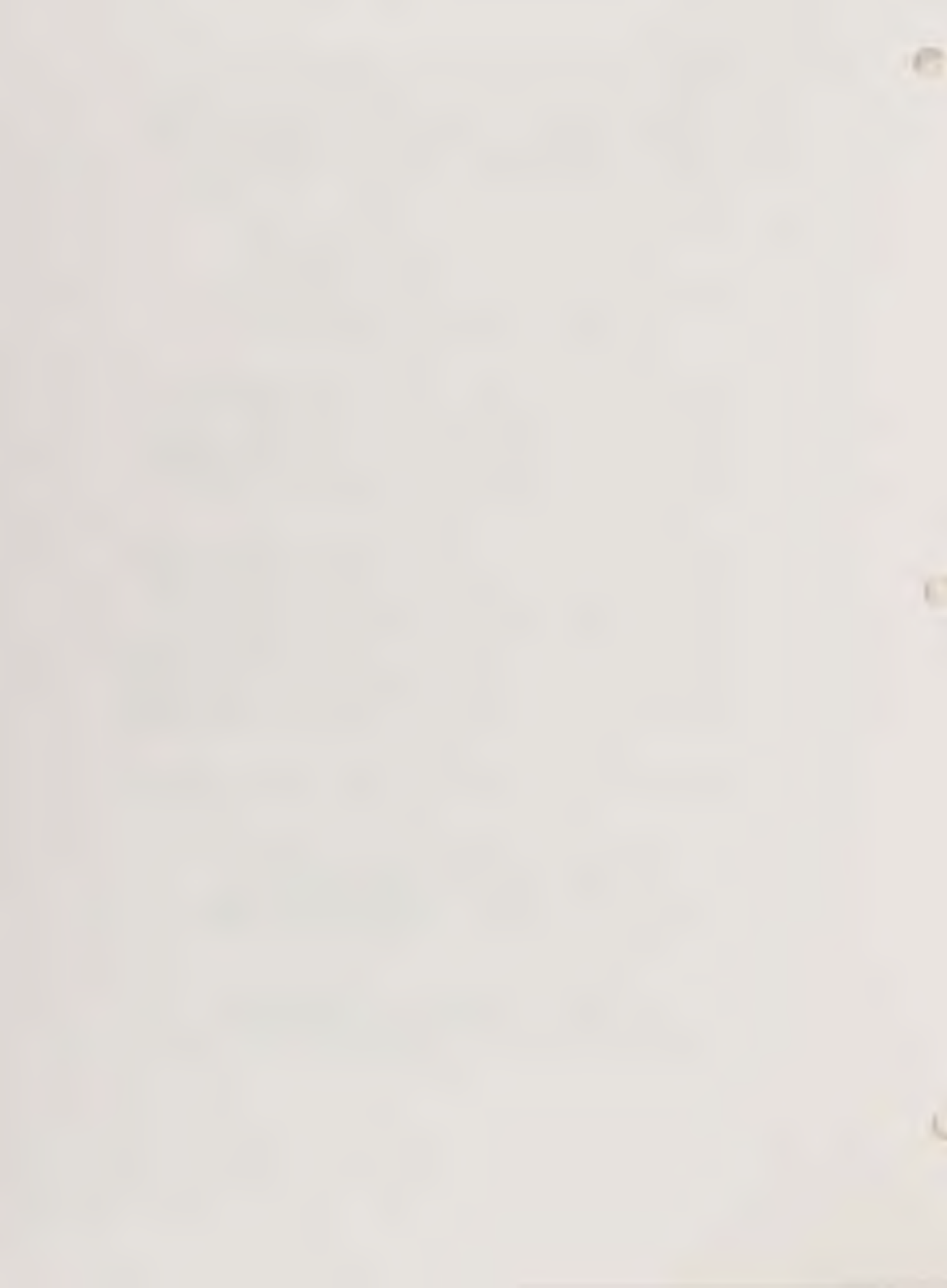
Previous research efforts regarding methadone detoxification has shown that removing methadone from someone who continues using heroin results in increased frequency of heroin use. However, to make the decision that a client is unable to discontinue heroin use may result in the staff's giving up on trying to help a client even reduce drug usage.

3. For almost all of the records reviewed, the quality of the counseling notes is not considered to be adequate by the evaluation team. Also, for some records reviewed, there were fairly long lapses in time between entries. For example, one record had no clinical entry from October, 1974 to February, 1975. In February, 1975, the client was discharged, but there was no discharge summary in the record. In this case, the client had been on the program for almost three years, and the process that led up to discharge could not be determined from the record.

To further illustrate the lack of adequacy of counseling entries, the following is excerpted:

July 12, 1972: " (Client's name) came to the group for the first time. (Client's name) was disappointed because most of the members were high and acting silly. (Client's name) voiced disapproval but got no feedback from the rest of the group."

May 24, 1973: (Same record) "(Client's name) attended group but had very little to say. Unsuccessful attempts have been made to see why _____ does not attend group."



Results of Record Review--Adequacy of Recordkeeping (cont'd.)

4. Over the years, take home privileges of methadone have been granted in this program, sometimes up to five times per week. It appeared that some clients had been granted take home privileges who probably should not have been. Take home privileges, when not carefully administered, can result in methadone diversion. Since diversion can result in a nonaddicted person's death and in illicit street use of methadone, granting take home privileges must be very carefully considered.

The following information, obtained from one social service record, serves to illustrate the type of record entries that led the evaluators to believe that take home privileges in this program may need to be more carefully monitored than they have been in the past:

- a. One client maintained on 50 mg. of methadone (an amount of methadone that should show up in the urine) during March and April, 1974, showed the following urine test results--

3/28/74 absence of methadone

3/30/74 take home privilege

4/7/74 take home privilege

4/8/74 absence of methadone

4/13/74 take home privilege

4/19/74 absence of methadone

4/20/74 take home privilege

4/21/74 take home privilege

4/27/74 take home privilege

4/28/74 take home privilege

4/29/74 absence of methadone

Information in the nurse's record did not collaborate with the information on urine results cited above. It is difficult to determine where the counselors obtained the information listed in this example.



Results of Record Review--Adequacy of Recordkeeping (cont'd.)

Not only are take home privileges of concern, but also adequate program supervision of methadone ingestion created some concern among the evaluators. The following is an example of the type of record entries that caused the evaluators to be concerned about surveillance of methadone ingestion. One client who had been on the program for 23 months, had 20 urine tests positive for morphine with methadone absent. Of the 20 positive tests, ten occurred when the methadone dose was 60 mg. or above. In October, 1975, the client showed morphine present and methadone absent for two urine tests. Furthermore, take home privileges had been granted for three weekends in October, 1975, with the client only remaining free of opiates for one month before the privilege was granted (this client was also arrested for theft and possession of narcotics while enrolled in West Oakland's program).

In 15 out of the 30 active cases reviewed, the evaluators had some concern about surveillance of methadone ingestion and/or the granting of take home privileges for the clients at some point in their treatment history on this program. Most of the problems seemed to occur in 1973 and 1974, though some did occur in 1975 as well.

Since records were chosen randomly, the evaluators have no reason to believe that records not reviewed would differ from those that were reviewed. Ideally, however, to be absolutely sure, more records would need to be reviewed in this program.

According to the last quarterly statistical report sent to the State by West Oakland, only nine urine tests out of 3,801 showed an absence of methadone or methadone metabolites in the urine. This may indicate that West Oakland has tightened up its surveillance of methadone ingestion, or the figure may be incorrect. There were some errors found on the last statistical report to the State, and there is no way to be certain from the data collected by the drug study team. The State has only recently begun to require quarterly statistical reporting, and it appears that the methadone program staff was not adequately prepared to fill out the reports.

In summary, records were found to be clinically inadequate and in need of immediate attention. More importantly, the rules that govern methadone dispensing and take home privileges need to be checked for consistency.

CLIENT CHARACTERISTICS - Table 2

Table 2 on the next page shows the characteristics of the clients sampled from West Oakland's program. The information was obtained by the drug evaluation team by searching through the clients' records. As can be seen, clients entering West Oakland's program are usually in their early thirties. A majority of the clients are male and a large percentage are Black. It is interesting to note that, as a group, clients who successfully detox are better educated and more likely to be female. Clients who have been on the program the longest (2½ years or more) were older when they entered treatment and less educated. Persons who left the program after being enrolled for only about three months were less often Black. Most clients in the program are married, either legally or common-law.

TABLE 2

CLIENT CHARACTERISTICS--WEST OAKLAND PROGRAM
N=50

<u>Client Categories</u>	<u>Age (When Entered Treatment) Mean</u>	<u>Education Mean</u>	<u>Male</u>	<u>Black</u>	<u>Married (Currently Married or Separated)</u>
Left Program after 4 months or less (N=10) (mean = 2.7 months)	28.2 *SD = 4.8	11.4 SD = 2.4	70%*	30%	70%
Enrolled under 1 year (N=10) (mean = 6.2 months)	32.7 SD = 9.9	11.4 SD = 1.27	70%	90%	70%
Enrolled more than 1 year, less than 2½ years (N=10) (mean = 17.1 months)	30.3 SD = 7.0	11.4 SD = .84	70%	70%	70%
Enrolled more than 2½ years (N=10) (mean = 37.4 months)	36.8 SD = 9.3	10.7 SD = 2.3	90%	40%	60%
Successful Detox (N=10) (mean = 29.7 months)	33.2 SD = 7.6	12.3 SD = 1.5	50%	90%	60%

* SD = Standard Deviation

Marital status and race are further broken down as follows:

<u>Client Categories</u>	<u>Married</u>	<u>Never Married</u>	<u>Separated</u>	<u>Divorced</u>
Left Program after 4 months or less (mean = 2.7 months)	5	1	2	2
Enrolled under 1 year (mean = 6.2 months)	6	1	2	1
Enrolled more than 1 year, less than 2½ years (mean = 17.1 months)	6	3	1	0
Enrolled more than 2½ years (mean = 37.4 months)	4	1	2	3
Successful Detox* (mean = 29.7 months)	4	1	2	2
TOTAL	25	7	9	8 = 49

* One person in this category was a widower

<u>Client Categories</u>	<u>Black</u>	<u>White</u>	<u>Chicano</u>	<u>Asian</u>	<u>Other</u>
Left Program after 4 months or less (mean = 2.7 months)	3	4	3	0	0
Enrolled under 1 year (mean = 6.2 months)	9	0	1	0	0
Enrolled more than 1 year, less than 2½ years (mean = 17.1 months)	7	2	0	0	1
Enrolled more than 2½ years (mean = 37.4 months)	4	3	2	1	0
Successful Detox (mean = 29.7 months)	9	1	0	0	0
TOTAL	32	10	6	1	1 = 50

INTAKE INFORMATION - table 3

Table 3 on the next page shows information obtained during the program's intake process for the clients sampled. Clients who have been on the program the longest (over 2½ years) had the longest addiction histories (Column V), the greater number of previous, nonmethadone treatment experiences, (Column II) and the longest run on heroin (Column VI). Adding that they were also older when they entered treatment and more poorly educated, they may, indeed, need treatment for a longer period of time. It should be noted that all of West Oakland's clients have fairly long runs on heroin. Also, a large percentage of them have been involved with the law for drug-related and/or other offenses (Columns XIII and IX). Overall, 68% of the clients had arrests for drug-related offenses prior to admission, and 84 percent had arrest for other crimes.

PROGRAM DATA - table 4

As can be seen from Table 4 on page 12, when remaining clean is measured in months, (Column I) clients enrolled in West Oakland's program do a little better after one year, but then increase their heroin use after being on the program more than 2½ years. However, since abstinence is not the only goal of this program, it should not be considered the only measure of the program's success. All clients decreased their use of heroin. Instead of using one or two times each day, some clients might have only been using one or two times each week or month. Furthermore, when one considers the extensive involvement with the criminal justice system these clients had prior to admission, it appears the program may be having some impact on decreasing this involvement (Column XIII and IX). Overall, clients enrolled in the program seem to have fewer arrests than they did before admission; but, just as heroin use starts to increase after one year's enrollment period, so, too, do arrests seem to increase.

The last quarterly statistical report that West Oakland sent to the State indicated that of 3,801 urine tests taken, 3,260 of them were positive for opiates. This amounts to about 86 percent of the tests taken for the quarter. West Oakland's statistical report must be accepted with caution, however. It showed, also, that 185 clients were tested and 45 of them were clean for the quarter, leaving 140 clients testing dirty. When the number of clients who tested positive for non-medical opiates is called for, West Oakland's figure is 208. This figure is definitely inaccurate, since it exceeds the number of active clients in the program.

Table 4 also shows that methadone dosages decrease as tenure in the program increases (Column II). However, when one considers the spread (standard deviation) of dosage levels for the client categories, one must conclude that for a number of clients on this program, doses tend to be fairly high. Moreover, decreases in doses over time do not appear to be related to remaining "clean," since longer-term clients (2½ years) sampled in this study were clean for shorter periods of time on the average than clients in the program more than one year.

On the average, clients who remained in the program longer received more take homes per week (Column VI). Take homes will be further discussed under "significant correlations" found for this program.

TABLE 3

INTAKE INFORMATION - WEST OAKLAND PROGRAM
N=50

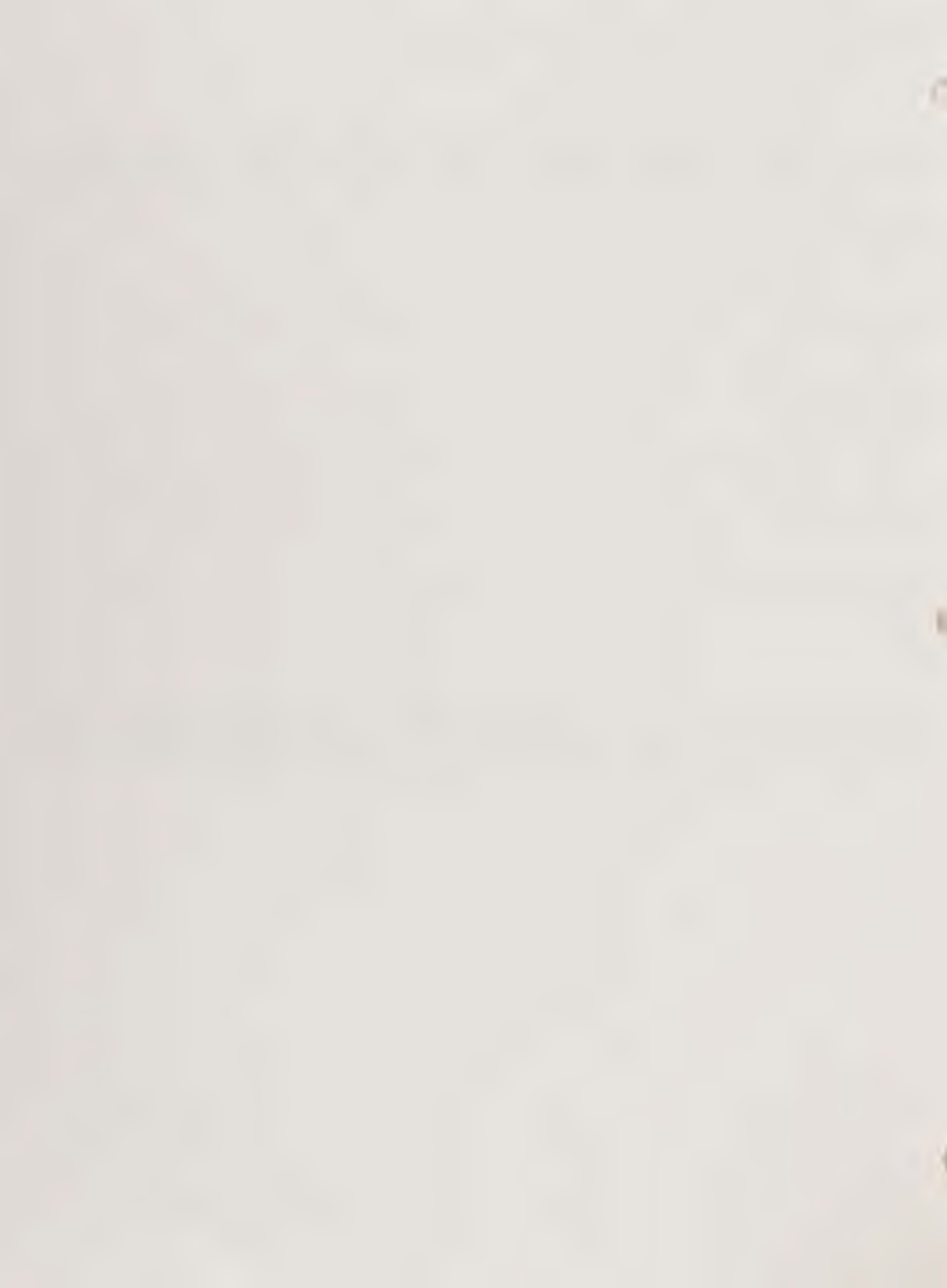
Client Categories	I Number of Previous Methadone Treatments Mean	II Number of Other Drug Treatments Mean	III Self- Referred	IV On Probation	V Number of Years Addicted Mean	VI Longest Run in Months Mean	VII Cost of Habit Mean	VIII History of Criminal Involvement for Drugs	IX History of Criminal Involvement for Other Crimes
Left Program after 4 months or less (N=10) (mean = 2.7 months)	.30 *SD = .48	3.0 SD = 2.1	50%	80%	6.7 SD = 3.8	30.4 SD = 26.8	\$102.50 SD = \$53.61	70%	100%
Enrolled under 1 year (N=10) (mean = 6.2 months)	.20 SD = .63	3.8 SD = 1.2	30%	80%	11.4 SD = 7.2	36.4 SD = 26.4	\$ 84.44 SD = \$40.96	80%	80%
Enrolled more than 1 year, less than 2½ years (N=10) (mean = 17.1 months)	.60 SD = .52	2.7 SD = 1.5	60%	80%	12.0 SD = 9.0	20.1 SD = 29.1	\$122.78 SD = \$63.84	60%	80%
Enrolled more than 2½ years (N=10) (mean = 37.4 months)	.00	4.4 SD = 3.1	70%	70%	18.6 SD = 8.8	52.5 SD = 29.9	\$ 75.00 SD = \$39.44	70%	70%
Successful Detox (N=10) (mean = 29.7 months)	.00	2.4 SD = 1.6	60%	70%	7.6 SD = 6.8	34.2 SD = 32.4	\$ 65.50 SD = \$19.44	60%	90%

* SD = Standard Deviation

Referral source is further broken down as follows:

<u>Client Categories</u>	<u>Self-Referred</u>	<u>Referred by Criminal Justice</u>	<u>Referred by Friends</u>	<u>Referred by Other Treatment</u>	<u>Referred by Family</u>	<u>Referred by Private Doctor</u>
Left Program after 4 months or less (N=10) (mean = 2.7 months)	5	1	2	1	1	0
Enrolled under 1 year* (N=10) (mean 6.2 months)	3	3	0	1	1	1
Enrolled more than 1 year, less than 2½ years (N=10) (mean = 17.1 months)	6	1	1	1	1	0
Enrolled more than 2½ years (N=10) (mean = 37.4 months)	7	2	1	0	0	0
Successful Detox (N=10) (mean = 29.7 months)	6 —	1 —	2 —	1 —	0 —	0 —
TOTAL	27	8	6	4	3	1

* One person in this category was referred by unknown source--information not in record. Except for clients who had been in the program less than one year, at least half of the clients in the other categories were self-referred. West Oakland, over the past year, may have been receiving an increase in referrals from criminal justice.



PROGRAM DATA - Table 4 (cont'd)

Clients who had been in the program over 2½ years averaged less than one individual counseling session per month (Column IV), as did clients who had been in the program over one year. Clients who had been in the program under one year, averaged slightly more than one individual session per month. The same frequency for groups was also found as determined by the number of group counseling sessions recorded in the clients' charts (Column V).

According to the last quarterly report sent to the State, 97 clients received 110 group sessions for the quarter. This would mean that West Oakland offered about nine groups weekly. The program has about 10 clients in each group. However, participation in these groups was stated by some program staff to be about 30 - 50 percent of clients enrolled. The number of one-to-one sessions reported for the quarter was 441. 133 people were cited as receiving one-to-one sessions for the quarter. This would mean that each client, on the average, received one individual session per month.

As can be seen from Table 4, the successfully detoxed clients were employed more often than the other client categories (Column VII). Whether this contributed to their detoxing is unknown. However, it is interesting to note that the percentage of clients currently employed increases as tenure in the program increases.

INTERVIEW DATA - Table 5

As can be seen in Table 5 on page 13, a large percentage of clients interviewed are using marijuana and alcohol (Column I and V). Since these drugs are used often by the general public, this is not very alarming. However, 35 percent (N=5) of the 14 clients interviewed had a drinking problem according to notes in their records and/or information provided by the clients themselves. All three persons interviewed who had been in the program under one year had a drinking problem. Several clients were somewhat intoxicated during the evaluation interview. Having a liquor store next door to the program makes control of alcohol ingestion difficult.

Almost all clients interviewed expressed the belief that they should participate in the program's decision-making processes (Column VII), and felt frustrated by their lack of input. As a group, they were satisfied with the program's hours (Column VIII) and felt that methadone was a safe drug in terms of its physical effects (Column IX).

Summary of Other Interviewing Data

The current physical health of the clients interviewed was generally rated by them as good, but was considered only fair prior to admission. All three clients in the program under one year said methadone did not interfere with their sexual functioning, but the four clients interviewed who had been in the program more than 2½ years said that it did. Just the same, almost all of the 14 clients interviewed said being on the methadone program had helped them to feel better about themselves. Relationships with family went from poor to good. Relationships with friends went from poor to fair, indicating some continued problems in this area. Changes for the better were attributed to the methadone program.

Table 4 relates to information obtained relative to the program experiences of the clients. This information was obtained by the evaluation team by searching through clients' records.

TABLE 4

METHADONE PROGRAM--RELATED INFORMATION
N=50

Client Categories	I Since Last Dirty Urine Results, Months Clean Mean	II Current Methadone Dose (mg.) Mean	III Since Program Entry, dirty Urines for Barbs or Amphetamines?	IV Number of one- to-one Sessions Mean	V Number of Group Sessions Mean	VI Number of Times Per Week--Take Home of Methadone Mean	VII Currently Employed?	VIII Arrested for Drugs Offenses While on Program?	IX Arrested for Other Crimes While on Program?
Left Program after 4 months or less (N=10) (mean = 2.7 months)	NA	51.4 **SD = 20.61	40%	4.0 *SD = 2.8	.70 SD = .82	.30 SD = .68	Unknown	10%	0
Enrolled under 1 year (N=10) (mean = 6.2 months)	1.4 *SD = 1.9	57.5 **SD = 16.54	80%	8.8 *SD = 4.2	8.5 SD = 9.5	.40 SD = .84	30%	20%	0
Enrolled more than 1 year, less than 2½ years (N=10) (mean = 17.1 months)	3.3 *SD = 4.5	54.5 **SD = 15.89	90%	12.2 *SD = 6.7	14.4 SD = 10.8	1.8 SD = 1.1	40%	20%	10%
Enrolled more than 2½ years (N=10) (mean = 37.4 months)	2.8 *SD = 2.4	41.5 **SD = 23.22	100%	22.2 *SD = 13.2	21.0 SD = 12.5	2.5 SD = 1.7	50%	30%	10%
Successful Detox (N=10) (mean = 29.7 months)	7.0 *SD = 6.9	NA	100%	16.4 *SD = 9.6	12.2 SD = 8.3	3.0 SD = 1.4	60%	0	0

* SD = Standard Deviation

Table 5 relates to information obtained from clients by the evaluators during interview sessions in November, 1975.

TABLE 5

INTERVIEW DATA - WEST OAKLAND
N=14

Client Categories	I Used Marijuana In Last Month?	II Used LSD In Last Month?	III Used Barbs In Last Month?	IV Used Amphetamines In Last Month?	V Used Alcohol In Last Month?	VI Used Other Non-prescribed Drugs In Last Month?	VII Should Clients Participate In Decision-Making of Program?	VIII Are you Satisfied With the Program's Hours?	IX Do you Believe Methadone Is Safe?
Left Program after 4 months or less (mean = 2.7 months)	(No one interviewed in this category)								
Enrolled Under 1 year (N=3) (mean = 6.2 months)	100%	0	0	0	100%	0	100%	100%	100%
Enrolled more than 1 year, less than 2½ years (=6) (mean = 17.1 months)	100%	17%	0	0	66%	0	100%	100%	50%
Enrolled More than 2½ years (N=4) (mean = 37.4 months)	50%	0	0	0	50%	0	50%	75%	75%
Successful Detox (Only one person inter- viewed in this category) (mean = 29.7 months)	yes	no	no	no	yes	no	yes	yes	no

Only two of the 14 clients interviewed felt counseling should be mandatory, and as a group, they rated the counseling services at West Oakland as fair. The program's stated requirement for clients to attend counseling sessions appeared to be inconsistently enforced. Clients complained that groups were often cancelled by the staff if not enough people showed up to attend them.

Selected Significant Correlations (Pearson r's)

Pearson r's were computed for the 30 clients who continued active on West Oakland's program. Some correlations have been selected to further clarify the program's impact on clients.

The number of take homes of methadone was related to tenure in the program ($r = .3762, p < .02$), but tenure in the program was not related to being clean as measured in months. Attending group sessions showed the greatest relationship to the number of take homes granted ($r = .6009, p < .001$). Perhaps this program rewards clients in this manner for obtaining counseling, or perhaps clients who attend group counseling are doing better in other functional areas, causing the staff to feel more comfortable about their progress.

The number of one-to-one or group counseling sessions attended did not relate significantly to remaining clean, methadone dosage levels, or any other programmatic factors except for tenure in the program. That is, the longer the client was in the program, the more counseling he/she received. Furthermore, of the 14 clients interviewed, the better educated clients gave the counseling services at West Oakland a significantly lower rating on quality ($r = .6076, p < .01$), and were less likely to obtain one-to-one sessions ($r = .4316, p < .009$).

In regard to dosage levels, clients who were currently employed were more likely to be receiving a lower dose ($r = .5898, p < .027$). People receiving higher doses were less often married ($r = .3626, p < .024$) and were more often on probation when admitted ($r = .4034, p < .01$). However, dosage levels did not significantly relate to a client's being clean as measured in months.

Overall, demographic data did not significantly relate to program impact. Older clients did have a longer history of addiction, as one might expect. Also, older clients were more likely to have a dirty urine within the last three months ($r = .4689, p < .005$). Since it is the older client that tends to remain on this program longer, one might conclude that these clients would be harder to successfully detox. As in Herrick's program, the possibility exists that West Oakland has at least two different types of clientele: those who may someday detox and for whom that expectation might be realistic, and those who may become maintenance clients over longer periods, perhaps for many years. Since West Oakland's program opened in

Selected Significant Correlations (Pearson r's) (cont'd.)

August of 1971, a total of 17 clients have been successfully detoxed by the program. However, not all of these clients can be considered successful program completors. What happened to the 10 clients identified in the category will be discussed shortly.

Reasons Given for Why Clients Left The Program After Being Enrolled Less Than Four Months

(This is all the information that could be gleaned from the records)

- 3 clients simply dropped out and never returned to the program.
- 2 clients transferred to Eden Methadone (one White, one Chicano).
- 2 were suspended for excessive absences.*
- 1 transferred to a program in San Jose.
- 1 transferred to a program in Los Angeles.
- 1 was discharged by the program for "lack of follow-through."

* One of the two was arrested before his suspension ended.

What Were the Successful Detox Persons Doing Now?

Only one client who successfully detoxed from West Oakland was interviewed. He was looking for work. Before leaving the program, he had been clean for eight months. At the time of the interview, he stated he had been clean for one year. He was not involved with the criminal justice system. He was living alone.

Three of the remaining nine clients in this category cannot be considered successes for the program. One left and went to another treatment program, and had not been maintaining clean urines at the time of departure. Another client also left the program, and the third client had only been clean for two months before discharge. The latter individual is a questionable success.

There are six clients left to discuss who appeared to be doing well at the time of discharge. One woman was fully employed, living with a friend and had been clean for five months before leaving the program. Another woman was living with her family and taking care of the home. She, too, had been clean for five months prior to discharge. One man was employed part-time,

What Were the Successful Detox Persons Doing Now? (cont'd.)

had been clean for 17 months prior to discharge and was living alone. He had been employed at time of admission. One man had been clean for 21 months before discharge, was fully employed and living with his family. One male had been clean for eight months prior to discharge, was unemployed when he left the program, and was living with friends. One female was clean for five months before discharge, was unemployed and living with a friend.

Summary of Impact of West Oakland's Program and Recommendations

West Oakland is accomplishing the goal of helping clients to reduce their use of narcotics. Also, the program seems to be helping some people keep out of difficulties with the law. People who stay on the program longer are more often working, but whether that is due to the program or inherent in the clients themselves, is unknown. Since longer-term clients had the best work histories, this finding probably cannot be attributed to the program.

Clients interviewed reported marked improvement in their relationships with family and friends, and attributed improvement to being on the methadone program. Also, their own self-images improved since program enrollment, as did their physical health.

There are many problems in terms of the program's functioning. Some of these were highlighted in the record review part of this section. It is recommended that the records of clients receiving take home privileges in this program be carefully reviewed. Also, program rules and regulations need to be consistently enforced so that clients know what is expected of them and do not feel personally affronted when they are denied a privilege. Higher dosage levels should be checked carefully, especially when urine results reveal an absence of methadone or methadone metabolites. Also, surveillance of methadone ingestion for clients showing an absence of methadone in the urine, especially when dosage levels are fairly high, should be strengthened, and take home privileges should not be given to these clients. Also, the clinical notes need to be improved, as indicated in the record section of this report.

The staff at West Oakland are faced daily with the very difficult task of trying to help persons whose problems are enormous, even if they were not addicted. The data cannot adequately describe the feeling one gets from being in the environment, even for a relatively short period of time. The poverty, the despair, the poor self-esteem, and the painful life experiences that many of West Oakland's clients know so deeply are difficult for those untouched by them to comprehend. Even so, West Oakland's staff needs to try harder to provide a treatment milieu that will be more likely to help their clients.

Recommendations:

1. Consistently enforce the stated program rules and regulations.
2. Review records to ascertain the appropriateness of granting take home privileges.
3. Correct inconsistencies between the nurses' and counselors' recorded urine test results.
4. Review, update, and improve the quality of clinical entry notes.
5. In cases where no methadone is found in the urine, review dosage levels and increase surveillance of methadone ingestion when appropriate.
6. Review records of clients on the program for two years or more and make appropriate, individualized justifications for their program continuance when justifications are not present in the record.

CLIENTS' COMMENTS

Clients' Comments

Only fourteen clients were interviewed at West Oakland due to several factors: 1) perhaps because of the life experiences of the clients, they were less inclined to volunteer to participate in the study, especially when volunteering would mean giving information to persons unknown to them; 2) several of the staff people tried very hard to solicit client participation, but others seemed somewhat reluctant to actively encourage clients to talk with us; 3) the evaluators did not feel especially welcome in the environment and did not make as much of an effort to be available after hours. In spite of these factors, the interviews were very meaningful, and clients' comments are offered here to help provide a perspective of the West Oakland program. We want to thank the clients who met with us and the staff persons who encouraged client participation.

Clients in Program Less Than One Year (N=3)

1. Groups are a waste of time. The staff calls them off cause not enough members show up....With methadone, you don't have to go out and steal everyday, but methadone is dope and I have to be here in the city everyday. I shoot dope one time every two weeks now instead of every day.
2. Taking methadone is better than shooting heroin everyday....They need job counselling here.
3. If you are sincere you can stay clean...when I'm using whatever I'm using, I might want to cut it (methadone) down....Three years some guys have been on the program. I don't want to be on that long....I can work a little now and I'm seeing more of my in-laws.

Client in Program More Than One Year, But Less Than Two and One-Half Years (N=6)

1. If I knew then what I know now about methadone, I never would have taken it--too hard to detox. People either die or use it again...they need more medical care here....Grouping is ridiculous. People go in and don't say anything. You can't talk to someone who has never been into dope. If you're gonna shoot dope, you're gonna shoot it. Methadone doesn't stop that. It gives me time to think if I want to shoot. It keeps you from being sick, but if you miss methadone, you get even sicker.

Client in Program More Than One Year, But Less Than Two and One-Half Years (con'd)

2. It takes a long time to kick methadone....Police get down on people with a methadone card....A lot of people are coming here for help and don't even know it...the program should have more one on one counselling.
3. Methadone is a worse addiction than heroin. It tears up your stomach and insides....I've gained more moral values of myself since being on the program.
4. Counselling depends on the person and what the person wants from it.... Life is too rough on heroin.
5. You shouldn't be on methadone for more than one year...worse than heroin, but better than being strung out on heroin.
6. I don't like grouping.

Clients in Program More Than Two and One-Half Years (N=4)

1. I sweat a lot on methadone....I had been clean for five years and had another person give dirty urines to get on the program. I was afraid of getting hooked again on heroin....The clinic should be more like a medical center instead of the "Club 68" atmosphere. It is not conducive to being drug free. I started shooting again through a contact at this clinic.
2. Methadone saved my life....I hope to detox. It's a major goal. But tell me, what's out there for me after I detox? That's what's needed. Maybe they should have a group for people who have made it.
3. You can get as much help here as you want.
4. Methadone has helped me not shoot dope....Detoxing from methadone is severe.

Successful Completer (N=1)

1. It depended on who was dispensing what dose I got. They had too many different people dispensing....The dependence on methadone was very difficult.

EDEN METHADONE TREATMENT PROGRAM (COUNTY) - IMPACT

Operated by the County's Health Care Services Agency, Eden's treatment program began in July, 1971. Since the program opened, about 368 clients have been admitted. At the present time, Eden's program has 150 authorized, funded treatment slots. In November, 1975, all of the slots were filled.

The program is located in the Eden Public Health District Building, 12001 Foothill Boulevard, San Leandro. Fairmont Hospital and the Sheriff's Department are nearby. The program occupies part of one wing on the first floor of the building, and several offices on the second floor. Conditions are generally crowded, with office space being shared. Urine specimens must be observed in public facilities, resulting in a lack of privacy for clients and staff.

The director of Eden's program is Keith Olson. Mr. Olson has been the director since the reorganization of the two County methadone programs in October, 1975. Dr. Richard Baldwin is medical director for this program. It should be noted that Dr. Baldwin recently submitted his resignation from the program, to be effective January, 1976.

Except for orientation group meetings, counseling is not mandatory in this program. Dispensing of methadone takes place between 6:30 a.m. and 9:45 a.m., and then again between 2:00 p.m. and 3:00 p.m., with some emergency dispensing from 4:30 p.m. to 5:00 p.m. Approximately three weeks before this evaluation began, clients were instructed by staff not to hang around the program after dispensing hours.

Very little client-centered activity, including counseling, was observed to take place during the nine working days the evaluation team spent in this program. The staff seemed to have quite a bit of time on their hands. Morale was very poor because of the County's reorganization of the program. Fairwell parties were being given, as several of the staff had already left the program and several more were planning to leave during the evaluation. When questioned about turnover, reorganization was cited as the major cause.

According to written guidelines, Eden's treatment goals are to free clients from dependence on the heroin black market, to discourage illicit drug use, to foster stability in clients' lives, and to increase the likelihood of eventual freedom from any drug dependence. Acts of violence while on the program result in a 15-day detox from methadone and termination from the program. Suspension for unsatisfactory program participation (continued use of heroin) is accomplished with a 30-day detoxification.

Take-home privileges are granted according to State regulations. No irregularities were observed. In general, rules seemed to be consistently enforced.

Table 1 on the next page shows the number of records reviewed at Eden's program by the evaluation team, the number of clients interviewed in each category, and the percent of the clients represented in each record review category.

TABLE 1

<u>Client Categories</u>	<u>Number of Records Reviewed</u>	<u>Number of Clients Interviewed</u>	<u>Total Number of Eden's Clients that Fit Each Category</u>	<u>Percentage of Total Represented in Record Review</u>
Left Program after 4 months or less (mean = 3.6 months)	10	0	N=12	83.3%
Enrolled under 1 year (mean = 7.2 months)	10	6	N=85**	11.8%*
Enrolled more than 1 year, but less than 2½ years (mean = 19.3 months)	10	5	N=26**	38.5%*
Enrolled more than 2½ years (mean = 45.5 months)	10	3	N=45**	22.2%*
Successful Detox (mean = 24.9 months)	10	3	N=11	90.9%
TOTAL	50	17		

* 19.2 percent of Eden's active clients had their records reviewed by the drug evaluation team.

** Eden's active clients add up to a total of 156. This is possible because programs are permitted to enroll 10 percent more clients than their number of funded treatment slots.

RESULTS OF RECORD REVIEW--ADEQUACY OF RECORDKEEPING

There are several problems with Eden's recordkeeping system:

1. Up-to-date results from urinalysis and most recent methadone dosage levels are kept at the nurse's station which makes the information rather inaccessible to the counselor during certain times of the day. The amount of effort needed for a counselor to get this information may, at times, preclude the counselor's obtaining it. Furthermore, when a client has been active for several years, his older records will be filed in a separate part of the building and only a few people on the staff seemed aware of how to get at the information. This made data collection rather difficult, and would certainly hamper continuity of treatment.

Results of Record Review--Adequacy of Recordkeeping (cont'd.)

2. For clients who had been in the program two years or more, justifications for maintaining clients on methadone were identical (word for word) in all cases reviewed. The justification read as follows:

"After two years on this methadone maintenance program, this patient continues to require the medical, pharmacological, and counseling services which we have to offer including, if indicated, reduction in dose and/or complete withdrawal from methadone."

It is hard to believe the same justification would apply to all clients, and, in fact, one of the clients for whom this justification had appeared, maintained clean urines for 51 months, the entire time on the program.

3. The quality of counseling entries is not considered adequate in this program. Although some clients were "seen" fairly often, general goals or the quality of the sessions cannot be determined since what was often recorded was, "patient seen today."
4. One record selected by the evaluators in the "four months or less" category had to be thrown out due to insufficient information in the record. There was no personal history information at all to be found. Another record in a different category had to be dropped from the evaluation due to the wrong urines being filed in the chart. Staff were not able to locate the client's correct urine records during the nine days the evaluators were working in the program.
5. The adequacy of intake procedures for some of the clients is questioned in that intake summaries were not available in all of the records. Previous treatment failures and drug usage history were almost always documented, but other important factors, such as educational attainment, employment history, or marital status were sometimes missing.

In summary, records were found to be inadequate, though rules and regulations, for the most part, were found to be consistently enforced.

CLIENT CHARACTERISTICS - table 2

Table 2 on the next page shows the characteristics of the clients sampled from Eden's program. As can be seen, most of Eden's clients are in their early thirties when they enter treatment. However, persons remaining in treatment for the longest period (2½ years or more) are older when they enter treatment and

CLIENT CHARACTERISTICS (cont'd.)

tend to be less educated. Eden has very few Black clients, unlike all three of the other methadone programs. People who stay in the program, when compared to those who leave after four months or less, are more often married.

TABLE 2

CLIENT CHARACTERISTICS--EDEN PROGRAM
N=50

<u>Client Categories</u>	<u>Age</u> (when entered treatment) Mean	<u>Education</u> Mean	<u>Male</u>	<u>Black</u>	<u>Married</u> (includes currently Married or Separated)
Left Program after 4 months or less (N=10) (mean = 3.6 months)	30.7 *SD = 8.1	11.8 SD = 1.6	90%	0	30%
Enrolled under 1 year (N=10) (mean = 7.2 months)	30.8 SD = 10.4	11.5 SD = 1.4	60%	0	50%
Enrolled more than 1 year, but less than 2½ years (N=10) (mean = 19.3 months)	29.4 SD = 5.8	12.2 SD = 1.5	60%	0	60%
Enrolled more than 2½ years (N=10) (mean = 45.4 months)	37.9 SD = 8.9	10.0 SD = 3.0	70%	10%	80%
Successful Detox (N=10) (mean = 24.9 months)	31.3 SD = 6.7	11.9 SD = .99	90%	10%	80%

* Standard Deviation

INTAKE INFORMATION - Table 3

As can be seen from Table 3 on page 6, people enrolled in the program for the longest time period, had no previous methadone treatment experience (Column I) but did have a substantial number of other treatment experiences (5.3 average - Column II). Since short-term detoxification was mentioned as the most frequent type of treatment received, it is not surprising that these clients continued to have a drug problem. The literature demonstrates that short-term detox is not effective in helping clients abstain from drug use after they leave treatment.

Marital status and race are further broken down as follows:

<u>Client Categories</u>	<u>Married</u>	<u>Never Married</u>	<u>Separated</u>	<u>Divorced</u>
Left Program after 4 months or less (mean = 3.6 months)	3	3		4
Enrolled under 1 year* (mean = 7.2 months)	4	3	1	1
Enrolled more than 1 year, less than 2½ years (mean = 19.3 months)	4	3	2	1
Enrolled more than 2 ½ years (mean = 45.4 months)	7	1	1	1
Successful Detox (mean = 24.9 months)	7	1	1	1
TOTAL	25	11	5	8 = 49

* One person in this category was widowed.

<u>Client Categories</u>	<u>Black</u>	<u>White</u>	<u>Chicano</u>
Left Program after 4 months or less* (mean = 3.6 months)		6	3
Enrolled Under 1 year (mean = 7.2 months)		9	1
Enrolled more than 1 year, less than 2½ years (mean = 19.3 months)		8	2
Enrolled more than 2½ years (mean = 45.9 months)	1	7	2
Successful Detox (mean = 24.9 months)	1	5	4
TOTAL	2	35	12 = 49

* One person in this category had no personal history information in his record. Race could not be determined.

The breakdown for race reveals that Eden has a large white population and a substantial number of Chicanos, as well.

Intake Information

Table 3 shows the information obtained during the program's intake process for the clients sampled. Information was gathered by members of the drug evaluation team by searching through the clients' records.

TABLE 3

INTAKE INFORMATION--EDEN PROGRAM N=50

Client Categories	I Number of Previous Methadone Treatments Mean	II Number of Other Drug Treatments Mean	III Self- Referred?	IV On Probation or Parole?	V Number of Years Addicted Mean	VI Longest Run in Months Mean	VII Cost of Habit Mean	VIII History of Criminal Involvement for Drugs?	IX History of Criminal Involvement for Other Crimes?
Left Program after 4 months or less (N=10) (mean = 3.6 months)	.40 *SD = .52	4.7 SD = 2.5	40%	70%	11.9 SD = 5.6	11.2 SD = 5.1	\$57.00 SD = \$51.81	90%	80%
Enrolled under 1 year (N=10) (mean = 7.2)	.60 SD = .84	5.4 SD = 2.4	60%	40%	9.2 SD = 5.5	36.0 SD = 34.8	\$95.55 SD = \$52.65	.80%	60%
Enrolled more than 1 year, less than 2½ years (N=10) (mean = 19.3 months)	1.1 SD = .74	2.9 SD = 1.6	80%	30%	9.1 SD = 5.0	43.0 SD = 29.7	\$93.12 SD = 75.07	70%	50%
Enrolled more than 2½ years (N=10) (mean = 45.5 months)	.00	5.3 SD = 2.6	50%	60%	18.2 SD = 10.3	29.00 SD = 22.0	\$65.55 SD = 38.85	70%	90%
Successful Detox (N=10) (mean = 24.9 months)	.33 SD = .71	2.6 SD = 1.6	70%	60%	8.1 SD = 5.5	18.3 SD = 10.7	\$71.43 SD = \$48.80	70%	90%

* SD = Standard deviation.

As in other programs, the majority of clients are self-referred (Column III). It is very interesting to note that clients who left the program were somewhat more likely to be on probation or parole (Column IV). Furthermore, when referral source is broken down (see next page), more of these clients are directly referred from the probation department. Evidently, this was not enough of an incentive for the clients to commit themselves to methadone treatment.

It is not surprising to find that clients who have remained in treatment the longest have the longest history of addiction (Column V), in addition to being older. These clients may, indeed, need a longer treatment experience. As in Herrick's and West Oakland's program, the data are suggestive of Eden having two different types of clients - those for whom detox may be a more easily obtainable goal, and those who may require treatment for a longer period.

Most of Eden's clients have had arrest histories, either for drugs or other crimes (Column VIII and IX). This is true of the clients in other programs, as well. As a group, 75 percent of Eden's clients had been arrested for drug related offenses prior to admission, and 73 percent had histories of arrest for other crimes.

PROGRAM DATA - Table 4

As can be seen from Table 4 on page 9, Eden's clients seem to decrease the amount of time they remain clean as they go from the under one year to the over one year status (Column I). However, clients who remain for 2½ years or longer, remain clean longer than any other client category, except for those who successfully detox. Successfully detoxed clients remained clean an average of 12.5 months before discharge. Considering that their average program tenure was only about 25 months, they were clean for approximately the entire latter half of the time they were on the program. Eden's last quarterly statistical report to the State (July 1, 1975, to September 30, 1975) indicated that out of 145 active clients, 70 of them had remained totally free of opiates for four months; 11 of these clients' records were reviewed by the evaluators as part of the study sample and this information was verified. However, this information should be balanced by the fact that Eden may be maintaining some clients who could possibly attempt detoxification. One of their successfully detoxed clients had been clean for three years, the total time he was on the program. Methadone dosage levels over that time went from as high as 80 mg. in his early stages of treatment down to 0 three months before discharge. One current client, already mentioned in the record review section of this report, had been clean for 51 months, the total time he was on the program. In November, 1975, he was receiving 40 mg. of methadone, and his dosage had been as high as 80 mg. in his early stages of treatment. Furthermore, clinical record entries revealed that several clients who had been remaining clean and who had requested detoxification were discouraged from attempting it by the staff.

When dosage levels are examined (Column II), puzzling questions arise. One wonders why persons in the program over 2½ years, who average more months clean, are on the higher doses of methadone. Also, the question comes up in reverse for persons in the program over one year who average the least number of months clean. Some of them are on fairly low doses of methadone. Whether being on lower doses relates to more dirty urines in a causative manner is

<u>Client Categories</u>	<u>Self-Referred</u>	<u>Referred by Criminal Justice</u>	<u>Referred by Friends</u>	<u>Referred by Other Treatment</u>	<u>Referred by Family</u>	<u>Referred by Private Doctor</u>
Left Program after 4 months or less* (mean = 3.6 months)	4	4	0	0	0	1
Enrolled under 1 year (mean = 7.2 months)	6	0	2		2	
Enrolled more than 1 year, less than 2½ years * (mean = 19.3 months)	8	0	0	0	1	0
Enrolled more than 2½ years * (mean = 45.4 months)	5	2	1	1	0	0
Successful Detox* (mean = 24.9 months)	7	1	0	0	1	0
TOTAL	30	7	3	1	4	1 = 46

* One unknown--record incomplete

Table 4 relates to information obtained relative to the program experience of the clients. Information was gathered by the evaluators by searching through the client's records.

TABLE 4

METHADONE PROGRAM--RELATED INFORMATION
N=50

Client Categories	I Since Last Dirty Urines Results, Months Clean Mean	II Current Methadone Dose (mg.) Mean	III Since Program Entry, dirty Urines for Barbs or Amphetamines?	IV Number of one- to-one Sessions Mean	V Number Of Group Sessions Mean	VI Number of Times Per Week--Take Home of Methadone Mean	VII Currently Employed?	VIII Arrested for Drug Offenses While on Program?	IX Arrested for Other Crimes While on Program?
Left Program after 4 months or less (N=10) (mean = 3.6 months)	NA	18.6 *SD = 24.95	0	11.4 SD = 7.0	.20 SD = .42	.20 SD = .64	Unknown	30%	30%
Enrolled under 1 year (N=10) (mean = 7.2 months)	4.4 SD = 4.0	43.0 SD = 9.77	30%	16.6 SD = 6.9	.30 SD = .48	1.0 SD = 1.3	50%	10%	10%
Enrolled more than 1 year, less than 2½ years (N=10) (mean = 19.3 months)	1.6 SD = 2.6	35.4 SD = 14.96	70%	24.5 SD = 16.3	.70 SD = 1.6	.70 SD = .95	60%	0	10%
Enrolled more than 2½ years (N=10) (mean = 45.5 months)	8.7 SD = 15.9	55.0 SD = 11.78	80%	48.8 SD = 22.7	.30 SD = .95	1.4 SD = 2.3	50%	0	10%
Successful Detox (N=10) (mean = 24.9 months)	12.5** SD = 13.0	NA	100%	27.6 SD = 18.0	.77 SD = 1.7	2.9 SD = 1.5	60%	0	0

* SD = Standard deviation

** 12.5 represents the average number of months clean prior to discharge.

unknown, but it certainly could contribute to the problem. Also, clients who left the program had very low doses of methadone. Several factors might account for this: one, they were not on the program long enough to receive higher doses. Most programs start clients off at 20 mg. and raise them by 10 mg. over a period of several weeks until the client reaches the dose felt to be most appropriate for his needs. However, since clients who left averaged about four months on the program, this does not seem to be an adequate explanation; two, since more of these clients were referred by probation and their criminal status was questionable, the program may not have wanted to addict these people to larger doses of methadone in case they were incarcerated in the near future. Since methadone for detox purposes can be obtained in prison, this may not be the reason for these clients receiving lower doses. At any rate, it seems odd that the newer clients received such low doses of methadone, and it may have contributed to their departure.

Eden's program has fewer group sessions (Column V) recorded than any of the other methadone programs. However, this finding must be balanced against the fact that they had the largest quantity of one-to-one counseling sessions recorded (Column IV). In Eden's last quarterly statistical report to the State, no group counseling sessions were noted by the staff. A total of 1,127 one-to-one sessions were recorded for 140 clients, or an average of about two and half sessions per client each month. As was pointed out in the record review section of this report, the quality of the clinical entries for the sessions is not very good. Consequently, it is hard to evaluate the intensiveness of the therapy.

The number of times per week methadone is taken home (Column VI) for each client category appears to be related to the number of months the clients are remaining clean (free of opiates). Clients who had been in the program over one year and who were not remaining clean received the fewest take homes, except for clients who had been in the program for a relatively short time (under four months). It is not surprising, then, that clients who successfully detoxed and had remained clean an average of 12.5 months had the largest number of take-home privileges.

More than half the clients on Eden's program are working (Column VII). Prior to program admission, clients were only working sporadically (occasionally odd jobs). Also, clients who remain on the program seem to have a decrease in their arrests for drugs and/or other crimes (Columns VIII and IX).

INTERVIEW DATA - Table 5

As can be seen from Table 5 on the next page, a large percentage of clients interviewed use alcohol and marijuana (Columns I and V), with almost no one reporting that they use other drugs (Columns II, III, IV and V). Since this is probably true of persons in our society generally, this finding is not very surprising. However, one person out of the three interviewed in the successful detox group had a drinking problem. Three of the six people interviewed who had been in the program less than one year also had a drinking problem. A total of six of the 17 clients interviewed had a drinking problem.

Most of the clients expressed the belief that they should participate in the program's decision-making policies (Column VII). Clients at Eden were generally upset over the lack of group counseling services and felt frustrated that very

Table 5 relates to information obtained from clients during interview sessions.

TABLE 5

INTERVIEW DATA--EDEN CLIENTS

N=17

	I	II	III	IV	V	VI	VII	VIII	IX
<u>Client Categories</u>	<u>Used Marijuana In Last Month?</u>	<u>Used LSD In Last Month?</u>	<u>Used Barbs In Last Month?</u>	<u>Used Amphetamines In Last Month?</u>	<u>Used Alcohol In Last Month?</u>	<u>Used Other Non-prescribed Drugs In Last Month?</u>	<u>Should Clients Participate In Decision-Making of Program?</u>	<u>Are you Satisfied With the Program's Hours?</u>	<u>Do you Believe Methadone Is Safe?</u>
Left Program After 4 months or less (mean = 3.6 months)	(No clients were interviewed in this category)								
Enrolled under 1 year (N=6) (mean = 7.2 Months)	66%	0	16%	0	66%	0	100%	50%	50%
Enrolled more than 1 year, less than 2½ years (N=5) (mean = 19.3 months)	80%	0	0	0	83% (N=6) *	20%	60 %	80%	60%
Enrolled more than 2½ years (N=3) (mean = 45.5 months)	100%	0	0	0	33%	0	100%	66%	66%
Successful Detox (N=3) (mean = 24.9 months)	100%	0	0	0	100%	0	100%	100%	100%

* Whenever possible, information from the records was recorded, even for clients not interviewed. For these cells, then, more clients may have been included in the averages than were interviewed.

little was going on in the program. They wanted more activities. Eden's last statistical report to the State showed no recreational or group activity sessions. Also, clients expressed the need for more one-to-one counseling (see clients' comments). Most of the clients were satisfied with the program's dispensing hours (Column VIII) and most felt methadone was a safe drug in terms of physical effects (Column IX).

Summary of Other Interviewing Data

The greatest improvement in physical health was reported by clients who had been in the program under one year. Health went from poor prior to admission to good after admission. For the clients as a whole, health went from fair/poor to fair/good. Seven of the 17 clients indicated that methadone interfered with their sexual functioning. Despite this, 16 of the clients reported that being on the methadone program helped them to feel better about themselves. Relationships with family went from poor to good, as did relationships with friends. These changes were attributed to the program.

Clients rated the counseling services as good/fair with about half of the interviewed clients stating that counseling should be mandatory at Eden. This is interesting since Eden does not require counseling, though they do encourage it.

Selected Significant Correlations (Pearson r's)

Pearson r's were computed for the 30 clients who continued active on Eden's program. Some correlations have been selected to further clarify the program's impact on clients.

The number of take-home privileges was significantly related to the length of time a client remained clean as measured in months ($r = .5341$, $p < .001$). There was a trend for clients to remain clean as tenure in the program increased ($r = .2862$, $p < .06$). This did not reach significance probably because clients enrolled over the one year period did increase their heroin use when compared to clients enrolled less than one year, and when compared to clients enrolled over two and one half years.

Dosage level was positively related to length of time in the program ($r = .4559$, $p < .006$), with clients who remained in the program longer receiving higher methadone doses. Dosage was not related to remaining clean in Eden's program.

Even though the number of group sessions recorded for Eden's clients was relatively small, a significant relationship was found for remaining clean and attending group sessions ($r = .3544$, $p < .03$). This was not found to be true for the number of one-to-one counseling sessions attended.

Demographic data did not relate to progress in the program except that older clients were likely to remain on the program longer ($r = .3542$, $p < .02$). Also, better educated clients were more likely to be employed at time of record review ($r = .3742$, $p < .025$).

Why Did Clients Leave the Program After Being Enrolled Four Months or Less?

The following is a summary of the information obtained from the records:

- 4 clients were incarcerated (two for violation of parole)
- 1 client was discharged for fighting in the clinic area and for refusing to give urines.
- 1 client was detoxed due to excessive dirty urines and staff questioning whether the client was ingesting methadone.
- 1 client was suspended for dirty urines and not coming to the clinic regularly.
- 1 client was suspended for being late six times while on program probation.
- 1 client was suspended for irregular attendance and during suspension was sent back to jail.
- 1 client was detoxed off the program (stated he wanted to get into another methadone program, dirty while on this program).

What Were the Successfully Detoxed Persons Doing Now?

Three of the 10 clients identified by the program as successfully detoxed cannot be considered successes for the program. All of them showed dirty urines just prior to departure.

Three successfully detoxed clients were interviewed and seemed to be doing well. One man reported being free of opiates for two years, eight months. He was living with his family and maintaining a full-time job. Another man had been clean for four years, was working full time and living alone. The third client interviewed also had been clean for four years, was working full time, and living with his family. All clients interviewed had been free of criminal involvement since program discharge.

The remaining four clients all should be doing well according to information found in their records.

Summary of the Impact of Eden's Methadone Program

Eden's program is accomplishing the goal of helping some clients abstain from heroin use and others to decrease their use of heroin. Also, persons who remain in the program seem to have a decrease in arrests for drugs and/or other offenses. Relationships with significant persons improve for clients who stay in the program,

Summary of the Impact of Eden's Methadone Program (cont'd.)

and physical health shows fairly rapid improvement. Finally, being in a methadone program seems to be helping some of Eden's clients obtain employment.

There are several problem areas needing attention in this program. Records need to be reorganized, according to the inadequacies pointed out in the record section of this report. The possibility of offering more group counseling, as well as other related counseling services, needs to be considered by the staff. Also, dosage levels should be reviewed, especially for clients who have been maintaining clean urines, and some of these clients might be ready for an attempt to detoxify from methadone. Dosage levels for clients in the program over one year but less than two and one half years should also be reviewed. Some of the clients sampled in this category were found to be on relatively low doses of methadone and were not testing clean.

In general, Eden's program seems to be helping a large number of clients remain relatively free of opiate use and free from criminal involvement. It needs to offer more counseling services, especially more group services, and improve its recordkeeping and clinical review procedures.

Recommendations

1. Implement more client-centered activity; i.e., groups.
2. Re-organize and implement a more uniformed and comprehensive record-keeping system to insure the medical-clinical continuity of treatment.
3. Review records of clients on the program for two years or more and make appropriate, individualized justifications for their program continuance when justifications do not appear in the records.
4. Record clinical entries so that client progress or lack of progress can be assessed.
5. Obtain all of the necessary psycho-social client information at time of intake.
6. Review records of clients who have been consistently maintaining clean urines to better assess their potential for detoxification.
7. Review the methadone dosage levels for clients consistently maintaining dirty urines to determine if their dosage level is too low.

CLIENTS' COMMENTS



CLIENTS' COMMENTS

A total of seventeen clients were interviewed at Eden's program. The staff actively solicited client participation, and the seventeen clients represent the total number who willingly volunteered to meet with the evaluators. We want to thank the clients and staff for their co-operation. The comments that follow will help provide the clients' perspective of Eden's treatment program.

Enrolled Under One Year (N=6)

1. I don't get enough methadone to hold me....They should give me methadone twice a day.
2. They shouldn't be so strict about take homes. They should leave it up to the counselor and the client together. They shouldn't kick people off the program for using every now and then either because methadone keeps them from stealing or pimping or whatever else they're gonna do otherwise to get their stuff.
3. This is a good program for a lot of people. Some people will never quit. I used to cop drugs at (another program) from a dealer on the program...not having people hanging around here is good and they should get rid of clients who stay dirty.
4. Counselling services are needed here....Methadone had helped me out financially. I have a home and a life now.
5. I don't think my dose is always right. I get sick sometimes and other times I'm nodding....I can't always give urines when they want them. Why can't urines be given any time a counselor is here?...No one knows what methadone does and I resent being used as an experiment...The staff tells people not to hang around, but people have nowhere to go....They should have a couple of patients in on staff meetings or at least have some patient say in their decisions.
6. Methadone has saved my life. I'm afraid the program might get closed down because of the people who use methadone to cut down their heroin habit.

Enrolled Over One Year, But Less Than Two and a Half Years (N=5)

1. I don't like the idea of still being addicted to a drug (methadone)....The staff puts everyone in one class--we're all junkies....They don't have enough latitude in bending the rules....They should get some of these people off the program and make room for more sincere people.
2. They give you a thirty day detox when you mess up too much and that's too quick.

Enrolled Over One Year, But Less Than Two and a Half Years (N=5)

3. Methadone has given me time to stabilize....Screening here is too loose.... Counselling services here are no good. This is just a dispensing station.... Policies are too strict.
4. I'm not as happy about methadone treatment as I used to be. I've done the rubber ball thing too much (back and forth on heroin)....I'd like to see them have groups here. They have a policeman orientation....A lot of people used to hang around, deal, talk dope talk. If they had something going on here to help people, there'd be an alternative.
5. Being on methadone I have to shoot too much heroin to get high so I forget about it....Eden is a decent program, but the staff is short-handed and the clinic is not well run now. I'm not even sure who's running this place now....Methadone should only be given to long time, hard-core heroin users.

Enrolled Over Two and a Half Years (N=3)

1. Methadone stabilizes people. They may use periodically, say two or three times a week. But this program is dealing with addicts and they should expect addicts to use and not come down hard on them.
2. Methadone is my drug for a life-time. If it had been available in the 50's, it would have been a life saver.
3. People are kicked off the program too easily....There's no client say in what the staff does. They need a patient council on something because there's a big rift here between patients and staff. The staff acts like policemen....The nurse here should check on the legal dosage of methadone because it's not holding some of the patients.

Successfully Detoxed (N=3)

1. I detoxed by myself. I was sick for a month. Detoxing off methadone is hard. This program discourages people from detoxing and the staff is ignorant about the effects of methadone.
2. The staff turnover here has caused clients a lot of problems...Detoxing is very severe. I had intense depression and body aches.

(One had no additional comments).

EAST OAKLAND TREATMENT PROGRAM (COUNTY) - IMPACT

Operated by the County's Health Care Services Agency, East Oakland's treatment program began in January, 1973. Since the program opened, about 118 clients have been enrolled (this figure does not represent the number of admissions, since some of the clients have been admitted more than once). At the present time, East Oakland's program has 75 authorized, funded treatment slots. In November, 1975, 73 of the slots were filled.

The program is located at 6400 Foothill Boulevard, across the street from a junior high school. The neighborhood can generally be described as a residential/business area. Upon entering the treatment facility, one immediately notices very dilapidated furniture. There have been some problems with theft on the premises, and the staff expressed reluctance to provide nice furnishings in the entrance area because of this.

The director of East Oakland's program is Mr. Timothy Ray, with Dr. Richard Baldwin acting as overall medical director. Dr. Baldwin's resignation has been submitted, effective January, 1976. Mr. Ray has been the director for about one year and four months.

Group and individual counseling are available at East Oakland, but not mandatory, although some one-to-one contact with a counselor is required. Also, attendance at an orientation group may be required of a new client. The goals of treatment are to help the addict abstain from the use of nonprescribed drugs and to help the individual attain his/her own personal, social, vocational, or educational goals. Dispensing hours are from 8:30 a.m. to 10:30 a.m. and from 4:30 p.m. to 5:30 p.m. On weekends, the hours are from 8:30 a.m. to 10:30 a.m. only. Violence, in or around the clinic, results in a 14-day detox and dismissal.

To earn a take-home privilege at East Oakland's program, a person must "mostly" remain clean for 90 days and be employed, in training, or in the home taking care of a family. When a new client is admitted to the program, the first 30 days are not counted as part of the 90-day period. Once a take-home privilege is earned, two dirty urine tests result in a loss of this privilege and the client must begin all over again.

Since November 1, 1975, more stringent rules have been established for clients who wish to remain on the program. Any member who has 50% or more of his urine test results dirty, receives a 30-day detox followed by a 30-day suspension. The person can then be readmitted to the program via staff decision. If he/she is readmitted, the rules again apply. There seems to be consistency in the program's enforcement of its new policies, but it is really too soon to know for certain.

Table 1 shows the number of records reviewed by the evaluators at East Oakland's program, the number of clients interviewed in each category, and the percent of the clients represented in each record reviewed category.

TABLE 1

<u>Client Categories</u>	<u>Number of Records Reviewed</u>	<u>Number of Clients Interviewed</u>	<u>Total Number of East Oakland's Clients that fit Each Category</u>	<u>Percentage of Total Represented in Record Review</u>
Left Program after 4 months or less (N=4) * (mean = 3.3 months)	4	0	4	100%
Enrolled under 1 year (N=10) (mean 7.6 months)	10	8	7	27.3%***
Enrolled over 1 year, but less than 2½ years (N=1) ** (17 months)	1	0	3	33.3%***
Enrolled over 2½ years (N=10) (mean = 27.3 months)	10	4	33	30.3%***
Successfully Detoxed (N=4) (mean = 15.5 months)	4	1	4	100%
TOTAL	29	13		

* East Oakland's program located only 4 clients in this category for the evaluators during the site visit.

** East Oakland's program located only 1 client in this category for the evaluators during the site visit. After the site visit, the program located two more clients that fit this category.

*** 27.4% of East Oakland's active clients had their records reviewed by the drug evaluation team.

RESULTS OF RECORD REVIEW--ADEQUACY OF RECORDKEEPING

East Oakland's program had the most complete intake information on clients when compared to any of the other programs visited. Also, the one-to-one counseling sessions were recorded in some depth, leading the evaluators to believe that the quality of counseling is probably adequate. Long and short-term goals were often clearly defined and this, too, was unique when compared with other methadone programs visited. However, other recordkeeping problems were noted as follows:

1. Justifications for clients remaining on methadone for two years or more were not found in all records.
2. Group therapy notes were not included in case records. Group attendance records were kept in a separate clinic file which made counting the number of sessions attended by each client very time consuming. Thanks to the help of the clerical staff of the program, evaluators did obtain this information. Just the same, it is recommended that group notes be maintained in the client's clinical chart for better continuity of treatment. As it is now, it is not possible to find out what happens to clients as a result of group treatment since only attendance records are kept for group sessions.
3. Up-to-date results from urine tests and current methadone dosage levels were not in the client's chart. To obtain the former, a clerk had to be consulted and to obtain the latter, a nurse had to be consulted. This made data collection somewhat burdensome for the evaluators and for the staff persons who cooperated with us, and could be a source of difficulty for the counselor who may be in immediate need of the information for continuity of treatment planning. Having to go to two separate staff persons for the information makes it more difficult to obtain, especially when the key people may not always be available.

In summary, East Oakland's records were fairly good in that intake information and one-to-one treatment contacts were recorded in some depth. Other sources of difficulty have been pointed out.

CLIENT CHARACTERISTICS - Table 2

Table 2 shows the characteristics of the 29 clients sampled from the East Oakland program. The information was obtained by the drug evaluation team by searching through the clients' records. As can be seen, clients entering the program are usually in their late twenties or early thirties. More than half of the currently active clients are male and Black. Clients who successfully detoxed tend to be better educated, younger when they enter treatment, male, and married. Clients who remain in the program over 2½ years are also likely to be married but somewhat less educated and only 60% were male.

TABLE 2

CLIENT CHARACTERISTICS--EAST OAKLAND
N=29

<u>Client Categories</u>	<u>Age</u> (when entered treatment) Mean	<u>Education</u> Mean	<u>Male</u>	<u>Black</u>	<u>Married</u> (includes currently married or separated)
Left Program after 4 months or less (N=4) (mean = 3.3 months)	27.0 *SD = 4.7	11.3 SD = .96	50%	50%	0
Enrolled under 1 year (N=10) (mean = 7.6 months)	28.6 SD = 7.9	12.0 SD = .82	70%	60%	40%
Enrolled over 1 year, but less than 2½ years (N=1) (17 months)	32.0	11.0	no	no	no
Enrolled over 2½ years (N=10) (mean = 27.3 months)	30.9 SD = 6.6	10.8 SD = 1.5	60%	70%	90%
Successfully Detoxed (N=4) (mean = 15.5 months)	25.7 SD = 1.7	13.0 SD = 1.2	100%	50%	100%

* SD = Standard Deviation

Marital status and race are further broken down as follows:

<u>Client Categories</u>	<u>Married</u>	<u>Never Married</u>	<u>Separated</u>	<u>Divorced</u>
Left Program after 4 months or less (N=4) (mean = 3.3 months)	0	3	0	1
Enrolled under 1 year (N=10) (mean = 7.6 months)	0	4	4	2
Enrolled over 1 year, but less than 2½ years (N=1) (17 months)	0	0	0	1
Enrolled over 2½ years (N=10) (mean = 27.3 months)	6	0	3	1
Successfully Detoxed (N=4) (mean = 15.5 months)	2	0	2	0
TOTAL	8	7	9	5 = 29

<u>Client Categories</u>	<u>Black</u>	<u>White</u>	<u>Chicano</u>	<u>Asian</u>	<u>Other</u>
Left Program after 4 months or less (N=4) (mean = 3.3 months)	2	1	1	0	0
Enrolled under 1 year (N=10) (mean = 7.6 months)	6	3	0	0	1
Enrolled over 1 year, but less than 2½ years (17 months)	0	0	1	0	0
Enrolled over 2½ years (N=10) (mean = 27.3 months)	7	1	1	0	1
Successfully Detoxed (N=4) (mean = 15.5 months)	2	1	1	0	0
TOTAL	17	6	4	0	2 = 29

Client Characteristics (cont'd.)

INTAKE INFORMATION - Table 3

As can be seen from Table 3, clients entering East Oakland's program usually had about three previous, nonmethadone treatment experiences (Column II). The one client who had been on the program over one year had as many as seven other treatment experiences, as well as one previous methadone treatment. About half the clients coming to East Oakland were self-referred (Column III). All four persons who left the program were on probation (Column IV), though only one of these was referred to the program by probation.

Clients who successfully detoxed tended to have shorter addiction histories (Column V) and shorter continuous heroin runs (Column VI) prior to admission. Clients who left the program also had shorter continuous runs on heroin prior to program entry.

Table 3 shows that regardless of the client category examined, arrests for drugs and/or other offenses runs high prior to program admission (Column VIII and IX). As a group, 86 percent of East Oakland's clients had arrest histories for drug related offenses and 83 percent had arrest histories for other offenses, such as robbery, forgery, and assault.

Referral source was further broken down as follows:

<u>Client Categories</u>	<u>Self-Referred</u>	<u>Referred by Criminal Justice</u>	<u>Referred by Family</u>	<u>Referred by Friend</u>	<u>Referred by Other Treatment</u>	<u>Referred by Private Doctor</u>
Left Program after 4 months or less (N=4) (mean = 3.3 months)	2	1	0	1	0	0
Enrolled under 1 year (N=10) (mean = 7.6 months)	5	2	2	0	1	0
Enrolled over 1 year, but less than 2½ years (N=1) (17 months)	1	0	0	0	0	0
Enrolled over 2½ years (N=10) (mean = 27.3 months)	4	0	0	5	1	0
Successfully Detoxed (N=4) (mean = 15.5 months)	3	1	0	0	0	0
TOTAL	15	4	2	6	2	0 = 29

Intake Information

-7-

Table 3 shows information obtained during the intake process for the clients sampled. Information was gathered by the drug evaluation team by searching through the clients' records.

TABLE 3

INTAKE INFORMATION--EAST OAKLAND PROGRAM
N=29

<u>Client Categories</u>	I Number of Previous Methadone Treatments	II Number of Other Drug Treatments	III Self- Referred?	IV On Probation or Parole?	V Number of Years Addicted	IV Longest Run on Heroin (months)	VII Cost of Habit Per Day	VIII History of Criminal Involvement For Drugs	IX History of Criminal Involvement for Other Crimes
Left Program after 4 months or less (N=4) (mean = 3.3 months)	0	3.5 SD = 1.3	50%	100%	8.0 SD = 3.5	13.0 SD = 8.2	\$61.25 SD = \$50.23	100%	100%
Enrolled under 1 year (N=10) (mean = 7.6 months)	.40 *SD = .70	2.7 SD = 1.4	50%	80%	8.1 SD = 5.1	27.8 SD = 26.7	\$50.50 SD = \$31.75	80%	90%
Enrolled over 1 year, but less than 2½ years (N=1) (17 months)	1.0	7.0	yes	no	15.0	24.0	\$75.00	yes	yes
Enrolled over 2½ years (N=10) (mean = 27.3 months)	.10 SD = .32	3.2 SD = 1.3	40%	80%	9.1 SD = 7.4	25.5 SD = 24.1	\$52.00 SD = \$22.01	80%	80%
Successfully Detoxed (N=4) (mean = 15.5 months)	.50 SD = .58	3.0 SD = .82	.75%	50%	7.3 SD = 3.2	12.3 SD = 4.0	\$61.25 SD = \$19.31	100%	50%

* SD = Standard Deviation

Table 4 relates to information obtained relative to the program experiences of the clients. Again, this information was obtained by the evaluators by searching through the clients' records.

TABLE 4
METHADONE PROGRAM-RELATED INFORMATION
N=29

Client Categories	I Since Last Dirty Urine Test Months Clean	II Current Methadone Dose (mg.)	III Since Program Entry, Dirty Urine for Barbs or Amphetamines?	IV Number of one- to-one Sessions	V Number of Group Sessions	VI Number of Times Per Week Methadone Taken Home	VII Currently Employed?	VIII Arrested for Drugs While on Program?	IX Arrested For Other Offenses While on Program?
Left Program after 4 months or less (N=4) (mean = 3.3 months)	NA	46.3 SD = 4.78	100%	6.3 SD = 3.3	3.8 SD = 2.5	.50 SD = .87	0	0	50%
Enrolled under 1 year (N=10) (mean = 7.6 months)	.90 SD = 1.5	35.8 SD = 9.17	.90%	12.2 SD = 4.9	13.3 SD = 6.8	.20 SD = .63	40%	20%	10%
Enrolled over 1 year, but less than 2½ years (N=1) (17 months)	0	40.0	no	37.0	9.0	.00	no	no	no
Enrolled over 2½ years (N=10) (mean = 27.3 months)	2.9 SD = 6.8	33.5 SD = 10.28	80%	25.8 SD = 7.1	42.0 SD = 22.9	.60 SD = .84	50%	10%	30%
Successfully Detoxed (N=4) (mean = 15.5 months)	5.0* SD = 3.7	NA	75%	12.3 SD = 9.9	18.3 SD = 10.2	1.8 SD = .96	50%	0	0

* Months clean prior to discharge

PROGRAM DATA - Table 4

As can be seen from Table 4 on page 8, East Oakland's clients do not remain clean for many months (Column I). In fact, the last quarterly statistical report to the State showed only four clients to be clean for the entire quarter. People sampled in the program under one year averaged less than one month clean. People sampled in the program over 2½ years only averaged about three months clean. Moreover, the successful detox clients only averaged five months clean prior to discharge. East Oakland recently (November 1, 1975) tightened up its regulations regarding suspension for clients who maintain dirty urines over 50 percent of the time for a 90-day period. From the data, this new regulation may result in more clients being dismissed from the program, making new admissions feasible. Or, it might be an incentive for clients to abstain from heroin use more than they obviously are doing now. It should be stressed that even though clients are not remaining clean for many months, all of them have reduced their heroin use. There were cases in which clients had been clean for months, and then would start using heroin again. The evaluators, however, only counted the months clean from the last dirty urine result.

Clients who left the program were generally on higher doses of methadone (Column II) but since they were relatively new to the program, this is not surprising. Active clients are given from about 25 mg. to 40 mg. at East Oakland. When one examines the spread of doses around the means, it is apparent that doses at East Oakland are fairly low and may be less effective in blocking withdrawal symptoms and heroin craving. According to the literature, 40 to 50 mg. is considered an adequate dose to prevent withdrawal symptoms. In looking over East Oakland's latest statistical report to the State, 37 people out of 73 were receiving less than 40 mg. of methadone.

East Oakland's clients generally do not get take home privileges (Column VI). This would seem appropriate in light of the urine test results. The latest statistical report showed that 58 out of the 73 clients had no take home privileges, and another 9 clients were allowed to take home methadone just one time per week. Only six clients on this program received more than one take home dose per week.

Slightly less than half of the clients sampled at East Oakland were employed on a part-time or seasonal basis (Column VII). Only a few of the clients interviewed said that being employed created conflicts in getting their methadone because of the clinic's dispensing hours. For some, this may be an excuse and for others it may not be. The program should probably re-evaluate its hours of operation for working clients.

Being enrolled in the program seemed to lessen the number of arrests for drugs and/or other offenses (Columns VIII and IX). This finding seems to be consistent across all methadone programs.

In regard to one-to-one counseling received (Column IV), persons enrolled in the program for about eight months (under 1 year) received about 1.5 one-to-one sessions per month. Persons enrolled over 2½ years received slightly less than one individual session each month. The latest statistical report that East Oakland sent to the State showed that 77 clients received 436 one-to-one sessions for the quarter. Each client on the average, then, reportedly received

about two individual sessions each month. This would amount to about one more individual session per person per month than was found by the evaluators for the sample selected randomly. Either East Oakland has recently increased its frequency of one-to-one sessions (July 1, 1975, to September 30, 1975), or they have failed to report (in the clinical records) all of the counseling sessions that they have delivered in the past.

In regard to group counseling (Column V), the quarterly statistical report showed that 39 people recieved 30 group sessions for the quarter. East Oakland, then, was providing about 2.5 group sessions weekly for the period of July 1, 1975, to September 30, 1975. Exactly how many clients attended each of the group sessions was not calculated by the evaluators. However, our tabulations showed that active clients received from one to two group sessions per month on the average.

INTERVIEWING DATA - Table 5

As can be seen from Table 5 on the next page, clients interviewed at East Oakland reported the use of marijuana, alcohol, and other drugs within the last month (Column I - VI). Other drugs included barbiturates, amphetamines, and other non-prescribed drugs, such as cocaine. Although none of the clients who successfully detoxed from the program or who were enrolled under one year had a drinking problem, six of the 10 clients enrolled over 2½ years did have a drinking problem. This was indicated in their clinic records and/or discussed with them during the evaluation interviews.

Table 5 also shows that most of the clients interviewed believed they should participate in decision-making processes of the program (Column VII). This seemed to take place at East Oakland. The clients, for the most part, were satisfied with dispensing hours (Column VIII), but the hours still may be a problem for a few working clients. The one client interviewed who had successfully detoxed did not feel that methadone was a safe drug. Most of the other clients interviewed, however, did believe it was a safe drug (Column IX).

Summary of Other Interviewing Data

The current physical health of the clients interviewed was described as good. Prior to program admission, health was described by them as fair. About one third of the clients interviewed who were currently active felt that methadone interfered with their sexual functioning. Most often delayed ejaculation or reduced sexual drive were mentioned as problems. Just the same, eight of the 13 clients interviewed believed being on the methadone program helped them to feel better about themselves. Relationships with family went from poor to fair, as did relationships with friends. Since interpersonal relationships were still not good for these clients, it would seem that a goal for future counseling services at East Oakland would be to help clients improve their personal relationships.

Overall, clients rated the counseling services at East Oakland as good. The one client interviewed who had successfully detoxed felt the services were inadequate. Clients enrolled in the program under one year rated the services as very good.

Table 5 relates to information obtained from the clients during interview sessions. Whenever possible, information from the records was added when it was available, even if the clients could not be interviewed.

TABLE 5

INTERVIEW DATA--EAST OAKLAND CLIENTS
N=13

<u>Client Categories</u>	<u>I Used Marijuana In Last Month?</u>	<u>II Used LSD In Last Month?</u>	<u>III Used Barbs In Last Month?</u>	<u>IV Used Amphetamines In Last Month?</u>	<u>V Used Alcohol In Last Month?</u>	<u>VI Used Other Non-Prescription Drugs in Last Month?</u>	<u>VII Participate In Program's Decision- Making?</u>	<u>VIII Satisfied With Hours?</u>	<u>IX Methadone Safe?</u>
(Clients who left the program were not interviewed, and the one client who had been in the program over one year refused to be interviewed)									
Enrolled under 1 year (N=8) (mean = 7.6 months)	50%	0	38%	40% (N=10)*	67% (N=9)*	33% (N=9)*	100%	75%	63%
Enrolled over 2½ years (N=4) (mean = 27.3 months)	83% (N=6)*	0	29% (N=7)*	20% (N=5)*	86% (N=7)*	40% (N=5)*	75%	50%	100%
Successfully Detoxed (N=1) (mean = 15.5 months)	50% (N=2)*	no	50% (N=2)*	50% (N=2)*	50% (N=2)*	no	yes	yes	no

* Information was added from the records for clients when it was available.

Summary of Other Interviewing Data (cont'd.)

Perhaps the quality of counseling has improved somewhat in the more recent past. Only about half of the clients interviewed felt counseling should be a requirement for methadone clients. At East Oakland counseling is not required, but clients are encouraged to obtain counseling sessions that are offered.

Selected Significant Correlations (Pearson r's)

Pearson r's were computed for the 21 clients who continued active on East Oakland's program. Some correlations have been selected for presentation to further clarify the impact of East Oakland's program.

Taking home methadone was significantly related to remaining clean ($r = .6672$, $p < .001$). This is what one would hope for in a well run methadone program. There was a trend for clients to be on lower doses of methadone if they were receiving take home privileges ($r = .3183$, $p < .08$). This would tend to reduce the risk of methadone diversion. Tenure on the program did not relate significantly to remaining clean, taking methadone home or dosage levels. This is a problem, in that being in the program over a period of time has not helped many people give up heroin for sustained periods.

There was a significant relationship found for remaining clean and receiving a lower dose of methadone ($r = .3799$, $p < .045$). The actual size of the correlation coefficient is moderate and probably would have been greater if many clients were not maintained on relatively low doses at East Oakland. Dose was also related to the number of group sessions attended, in that the more group sessions a client received, the more likely his dose was to be lower ($r = .4490$, $p < .021$). This was not found to be true for one-to-one sessions. Perhaps the clients who were attending more group sessions were doing better, or perhaps the staff were able to keep in closer touch with them, making lower doses more possible. Group attendance was also related to taking methadone home ($r = .4873$, $p < .046$) and not being arrested for nondrug crimes while on the program ($r = .3800$, $p < .045$).

Having a drinking problem was significantly related to remaining clean for longer periods ($r = .4356$, $p < .046$). Again, at least for some people, coming off of heroin may result in heavier drinking.

No significant relationship was found in this program between educational status and subsequent employment. Demographic data were not correlated in any meaningful way to progress in the program.

Why Did Clients Leave the Program After Being Enrolled Four Months or Less?

(Information obtained from the records)

Only four clients left East Oakland's program during the last fiscal year after being enrolled for four months or less. Three of them were incarcerated. Since all four had been on probation and had recent arrests, this is not very surprising. One client asked for detoxification after indicating she was not ready to give up drugs.

What Were the Successful Detox Persons Doing Now?

Since East Oakland opened early in 1973, four people have successfully detoxed from the program. One of these people was interviewed. He had been clean nine months before discharge and said he was remaining clean. He was unemployed, living with a friend and had not been arrested for any offenses since program discharge. Two of the other three clients had been clean for relatively short periods before discharge--one male had been clean one month before leaving the program and the other male had been clean for three months. Only one of them was employed at time of discharge. Whether they are doing well at this time is uncertain. The fourth client, a male, was clean for seven months before discharge, was fully employed and living with his family. All indications from the record would lead one to believe he is doing well at this time.

Summary of the Impact of East Oakland's Methadone Program

Clients at East Oakland are reducing their use of heroin, but very few of them are remaining drug free for very long. Perhaps the program's new regulations will provide an incentive for more clients to give up using heroin. People who remain in the program seem to get arrested to a much lesser extent than they did before entering treatment. Also, they feel better about themselves and report improved relationships with significant persons in their lives.

The records at East Oakland need to be reorganized to solve the problems identified under the record section of this report. Methadone dosage levels need to be reviewed since many clients are not remaining clean for very long on this program and doses tend to be low. Low doses could be contributing to the frequency of heroin use at East Oakland.

Counseling, especially group counseling, seems to be helping clients in the program. However, the quantity of services delivered over about the last two and a half years is not very great. There is some indication that frequency of counseling is increasing, and perhaps even more staff effort could be made in this area.

Since clients in this program reported using other drugs to a larger extent than did clients in the other programs, staff may need to offer extra incentives or other forms of assistance to help with this problem. This is especially true for longer term clients with drinking problems.

In general, East Oakland's program seems to be having some impact on the drug problem and the evaluators believe the staff is committed to helping the clients they serve. The evaluation team wishes to encourage the program to keep a close watch on the effects of its new regulations regarding maintaining 50% clean urines over 90 days to see how that influences the program's future impact.

Recommendations

1. Restore and clean furniture in facility entry and visiting area.
2. Review records of clients on the program for two years or more and make appropriate, individualized justifications for their program continuance when these justifications do not appear in the record.
3. Re-organize and implement a more uniformed and comprehensive record-keeping system to insure the medical - clinical continuity of treatment, i.e., maintain group entry notes and current dosage levels in the principal chart.
4. Review methadone dosage levels to determine whether current levels are sufficient for individual clients.

CLIENTS' COMMENTS

Clients' Comments

A total of thirteen clients were interviewed at East Oakland. More than thirteen volunteered to be interviewed, but several failed to keep scheduled appointments. This program had fewer clients in three of the five client categories than did the other programs. This fact partially explains why fewer clients were interviewed. The staff was very co-operative in attempting to solicit client participation. We want to thank them for their help, and also we want to thank the clients for their willingness in sharing their personal feelings with us. The comments that follow will help to provide the clients' perspective of East Oakland's treatment program.

Enrolled Under One Year (N=8)

1. Methadone doesn't make you feel loaded like heroin does...doesn't drive you... the program maintains you on a lower dose which doesn't make you into a vegetable....The staff attempts to get you into counselling....
2. Methadone makes you too drowsy...feels like the Heroin nod....
3. When I got on methadone I was not hooked....I can't work because the clinic doesn't open early enough for dispensing....
4. The counselors at East Oakland give individual attention to the clients.... Methadone has only helped me....
5. Because of the hours of the clinic (not early enough in the morning), I have a hard time getting my methadone and getting to work on time....
6. Kicking methadone is much more severe than kicking heroin...the time period is much longer and more severe...methadone physically hurts you worse than heroin does....The program needs more counselling and other activities....
7. Methadone enables me to work and make money and not run the streets....
8. People under twenty-one should be able to get methadone if they need it....

Enrolled More Than One Year, But Less Than Two and a Half Years

The one client in this category refused to be interviewed.

Enrolled More Than Two and a Half Years (N=4)

1. I feel that the hours for dispensing are set up mainly for the staffs' convenience; I prefer early morning hours due to my working schedule.

OVERALL COMPARISON BETWEEN THE FOUR METHADONE PROGRAMS

Adequacy of Record Keeping

Herrick's records were organized better than the records in any other methadone program visited. All information for a client could be found in one clinic chart, and forms were always found to be in the same place in each chart. Staff were careful to lock records up at the end of the day. East Oakland's records had the most complete intake information, and one-to-one counselling sessions also were recorded in depth. The most serious inadequacies were found in West Oakland's records. Eden, too, had record inadequacies that needed immediate attention (for further details, refer to those sections of the report).

Client Characteristics

Eden had the largest percentage of white people enrolled. West Oakland, in its earlier years, may have had more white clients than the program now has. The newer admissions who remain in the program more than four months tend to be almost all black. East Oakland and Herrick have about half their populations black and about half white. Table 1 shows that Herrick's clients obtain the highest educational level prior to admission. Clients from the other three programs seem to be comparable in terms of education. These factors should be kept in mind when attempting to compare the programs' impact.

Intake Information

As can be seen from Table 1, West Oakland's clients have the longest histories of addiction, with Eden's clients having somewhat shorter histories. Herrick's and East Oakland's clients appear to have similar averages for this variable. It should also be remembered that West Oakland's clients and East Oakland's clients are more likely to be on probation or parole when they enter treatment.

Program Data

Table 1 on page 4 shows that West Oakland and East Oakland clients have the poorest record for remaining clean when measured in months. Herrick's clients

have the best record and Herrick's program has definitely been the most disciplined in this area. Clients more frequently get suspended for remaining dirty at Herrick. East Oakland changed its policies on November 1, 1975, and more clients will either remain clean or get suspended in the future. Since all programs impact heroin use, suspending persons who use more heroin than others will most probably result in their increased use of heroin once off the program. There are several points of view to keep in mind when changing policies about dismissal or keeping clients in a methadone program. As Wilmarth and Goldstein¹ indicated, "It is important to recognize that even patients who appear to be failures according to strict criteria (eg., those who may use once or twice weekly) have nevertheless substantially decreased their use of heroin.... We believe, therefore, that discharge of patients because they continue some use of heroin is counterproductive, unless it can be shown that other patients are significantly helped thereby, through improvement of program morale or a deterrent effect of such a policy." Stressing a somewhat different perspective, Bayer² pointed out, "it should be understood that a program's response to repeated heroin abuses not only has implications for those who are currently abusing but for those who are not. The extent of drug abuse within a program must be controlled so that an atmosphere which is perceived by patients as permissive in this regard does not develop. Such an atmosphere threatens the ambivalent patient and can contaminate a treatment population."

As can be seen on table 1 on page 4, West Oakland's clients are on larger doses of methadone than are the clients in the other three programs. East Oakland's clients are on the lowest doses. Dosage levels can be critical in a methadone treatment program, since very high levels can cause clients to feel loaded and enhance the possibility of methadone diversion, and since very low doses are less effective in preventing withdrawal symptoms, increasing the potential for heroin use. As was mentioned in the sections of this report that dealt with these two programs, dosage levels should be reviewed. In West Oakland's program there is evidence to suggest that methadone ingestion needs to be more carefully watched. Absence of methadone in the urine was too often found in the charts, even when clients were on fairly high doses.

Comparing the quantity of counselling services, Eden's clients received more one-to-one counselling. However, since they received almost no group counselling, this finding must be balanced with that in mind. Furthermore, the quality of counselling at Eden cannot be determined from the types of entries made in the records since what is often recorded is "patient seen today". Herrick's program did not consistently record sessions in its earlier years, and the average number of sessions listed is a definite underestimate of sessions delivered. It should be noted that West Oakland is providing the fewest one-to-one counselling sessions as revealed by their records.

Table 1 shows that West Oakland's clients received an average of more take home privileges weekly than did clients in any other program. East Oakland's clients got the fewest number of weekly take homes. Considering

the fact that West Oakland's clients do not tend to remain clean for many months, the number of take homes granted to a client weekly should be reviewed, as was indicated earlier in this report.

SUMMARY OF THE FOUR PROGRAMS' IMPACT

The following conclusions relate to the five impact criteria identified in the methodology:

1. All four of the methadone programs seem to be helping clients reduce their heroin use.

The total amount of time a client was clean while on a program was not calculated. It would have required counting every clean day, and at best, this would have only been an estimate since clients do not have their urines tested every day. Therefore, the evaluators only counted the amount of time a client remained clean since the last dirty urine test result. In going through the records one by one, it was obvious that all clients who remained in treatment had cut down on their heroin use. Some would go for many months without using heroin at all, but would then start up again, sometimes for short periods.

2. Clients seem to reduce their criminal involvement as a function of being on a methadone program.

Arrest factors are harder to evaluate than reduction of heroin use for the following reasons:

- Clients had a longer period of time before entering treatment in which to commit crimes.
- We do not know how many crimes would have been committed had they never entered treatment. However, other studies suggest that crime rates do significantly increase once clients leave drug treatment programs, especially when treatment is short term. Since many clients remain in methadone programs for a year or more, it is highly probable that the programs are having an impact on arrest rates.

3. Clients' interpersonal relationships with family and friends were reported by clients to improve across all programs.
4. Clients' feelings about themselves improved as a function of being on a methadone program.

5. It cannot be said that being on a methadone program, per se, results in greater employment.

For some clients with good educational backgrounds and fairly good work histories, being relatively free of heroin and on methadone may help them function in a way that enables them to seek out and maintain a job. For others, with poorer educations and poorer work histories, methadone cannot necessarily help in this regard. This is especially true now as jobs get harder to find.

Where do we go from here? Should we have more slots in Alameda County available for methadone treatment? The final chapter of this report deals with this question. Unfortunately, there can be no simple answer and the complexities of the issue will be presented.

TABLE 1

SIGNIFICANT DIFFERENCES BETWEEN ACTIVE CLIENTS IN THE FOUR METHADONE PROGRAMS

SIGNIFICANT DIFFERENCES BETWEEN HERRICK AND WEST OAKLAND										
Variables	Herrick		West Oakland		Eden		East Oakland		F-ratio	Significance Level
	Mean	N=30 Standard Deviation	Mean	N=30 Standard Deviation	Mean	N=30 Standard Deviation	Mean	N=21 Standard Deviation		
<u>Demographic:</u>										
1. Last grade completed in school.	12.8	1.8	11.2	1.6	11.3	2.2	11.4	1.3	5.51	p < .002
<u>Intake Information</u>										
1. Number of years addicted.	8.5	5.1	14.1	8.8	12.2	8.3	8.9	6.2	3.70	p < .01
<u>Program-Data</u>										
1. Since last dirty urine, how long has client remained clean (in months)?	7.3	9.3	2.5	3.1	4.9	9.7	1.8	4.8	3.06	p < .03
2. Current methadone dose.	36.0	13.9	51.2	19.5	44.5	14.5	34.9	9.4	7.03	p < .0002

TABLE 1 (continued)

	<u>Herrick</u>		<u>West Oakland</u>		<u>Eden</u>		<u>East Oakland</u>		<u>F-ratio</u>	<u>Significance Level</u>
	N=30		N=30		N=30		N=21			
	<u>Mean</u>	<u>Standard Deviation</u>	<u>Mean</u>	<u>Standard Deviation</u>	<u>Mean</u>	<u>Standard Deviation</u>	<u>Mean</u>	<u>Standard Deviation</u>		(Probability less than)
3. Number of one-to-one entries in record (not a reflection on quality, just quantity).	19.77	13.79	14.40	10.33	29.97	21.26	19.86	9.77	5.72	$p < .001$
4. Number of group entries in record (not a reflection of quality, just quantity).	22.20	23.16	14.63	11.83	.43	1.07	26.76	21.90	13.2	$p < .0001$
5. Number of times per week methadone taken home.	1.17	.87	1.57	1.52	1.03	1.59	.38	.74	3.63	$p < .01$

References

- ¹Stephen S. Wilmarth and Avrom Goldstein, Therapeutic Effectiveness of Methadone Maintenance Programs in the U.S.A., Geneva, World Health Organization, 1974, pg. 14.
- ²Ronald Bayer, M.A., Eleanor Kremen, M.A., NSW, "An Examination of Repeated Heroin Abuse by Patients Maintained on Methadone." Fifth National Conference on Methadone Treatment, New York, 1973, pg.1096.

RECOMMENDATIONS AND DISCUSSION

The following points are appropriate with respect to methadone issues. Therefore, we recommend:

1. All four methadone programs be kept open with their existing slots.

No immediate increase in slots is recommended at this time. The reasons for this are many. To begin with, Alameda County has not determined its drug treatment needs, and to increase slots without knowing about how many addicts need treatment would be unwise. It has been estimated that there were about 250,000 to 650,000 people in the U.S.A. addicted to heroin in 1973.¹ Farther, it has been suggested that in urban centers prevalence is about one addict per thousand population. Applying this estimate to Alameda County with a population of about 1.4 million, the number of heroin addicts would be approximately 1,400. Currently, there are 525 funded treatment slots in the four methadone programs. Whether there should be more slots cannot simply be answered by counting addicts. Not all heroin addicts want or need methadone treatment. Also, there is much controversy currently about the efficacy of methadone treatment, especially since methadone is a very addicting, opiate drug.

It is simply not adequate to determine need based on the number of people on a waiting list, as some people suggest. As was pointed out in this report, some people currently on methadone programs probably should attempt detoxification. Some persons may not have been addicted to heroin when admitted.

2. Screening and case review procedures be tightened up within existing methadone programs before deciding to increase slots.
3. Programs should endeavor to develop short and long term goals with their clients, and periodically review these goals.

It has been pointed out that the addict seeking assistance faces considerable conflicts.² Many clients come to methadone treatment with a great deal of ambivalence. Black, Chicano, and other minority groups may view methadone treatment as the middle-class, white man's way of control. When faced with prison, the street, possible death, or the clinic, the addict may chose the clinic. However, the danger for the client, and the community, is that the client may feel compelled to distance himself from the clinic staff, who represent the governmental agents of methadone

dispensing. Perhaps this ambivalence at least partially accounts for the limited amount of counseling that was found to go on in the methadone programs studied. Ball, Graff, and Sheehan³ have indicated that a crucial component for success in any program is the attitude of the patient to the therapy. Realizing that many methadone clients may have conflicts about the treatment, staff people in the clinics need to aggressively reach out to help them deal with these and other problems. For some clients, presenting treatment at time-limited from the very beginning may permit the client to feel that he is freeing himself of methadone as he achieves certain objectives that are necessary for his effective functioning.⁴

4. Alternative modes of drug treatment need to be explored more thoroughly before deciding to increase the capacity of any existing drug program.

For example, during the process of this evaluation, team members visited the Drug Addiction Research Center in Palo Alto where LAAM (Levo alpha acetyl methadone, a derivative of methadone) is being researched for its efficacy in treating heroin addicts. Over about the last nine years, LAAM has been undergoing tests as a possible alternative to methadone treatment. Its benefits over methadone include: 1) it is long acting and so clients do not need to come to the clinic everyday. Dosage every two or three days is sufficient; 2) because it is long acting, take home privileges and the problems involved with take home, are eliminated; 3) LAAM produces no euphoria and since take homes are eliminated, street value of the drug is almost non-existent. It should be mentioned that to be admitted to the treatment program in which LAAM is administered, complete screening is done on all applicants. Potential clients are required to undergo a naloxone withdrawal test at the clinic, as well as the usual urine tests.

Another alternative to methadone treatment that is currently under debate is heroin maintenance. The drug evaluation team did not attempt to explore in any depth the arguments in favor or against heroin maintenance. However, one point should be made clear. Heroin is not a long acting drug and clients would need frequent "fixes" to prevent withdrawal symptoms. In an article to appear soon in Archives of General Psychiatry, Goldstein⁵ proposes that addicts go through several stages in treatment. Before describing the stages, Dr. Goldstein points out that the incidence and prevalence of heroin addiction are influenced by the availability of heroin. If it were available without constraints, its use would increase. He recommends seven stages of treatment for the addict: 1) for a one month period, allow the confined heroin addict to inject morphine intravenously 3-4 times daily, under nursing supervision; 2) for a one month period, allow the addict a subcutaneous administration of morphine by a nurse or physician. This would eliminate the "rush"; 3) for a maximum of six months dispense methadone daily by mouth; 4) LAAM given orally three times weekly for a maximum of one year; 5) LAAM withdrawal and abstinence encouraged with an opiate antagonist, naltrexone, offered to those in danger of relapse; 6) abstinence without pharmacologic support, but with weekly staff support; 7) abstinent and socially rehabilitated clients achieve inactive status.

Goldstein's treatment approach is pointed out only as an illustration of the need for responsible persons in Alameda County to explore new treatment ideas. Currently, drug free therapeutic community personnel stand on one side, while methadone maintenance personnel stand on the other, with little dialogue taking place regarding future program planning. It is interesting to note that a therapeutic community in which methadone is dispensed has never been undertaken in this county. The evaluators are not advocates of methadone T.C.s, but merely raise the question of whether such an approach might be beneficial for some clients. Time-limited treatment and other, newer alternatives to methadone programs, such as LAAM, have not been adequately investigated by persons responsible for future planning in Alameda County. The number and types of treatment programs provided should not be based on "what is", but rather on carefully guided study and repeated evaluation. Before more methadone slots are authorized and funded, further exploration of drug treatment approaches needs to be made. Also, the methadone programs currently in existence need to improve in the problem areas identified by this evaluation, and follow-up research on these programs should be conducted.

Summary

There is no easy remedy to the complex problem of addiction. There is no clear understanding of its causes. Certainly some responsibility for addiction rests with our country's social, political, cultural and economic conditions. There is some indication that for some people there may be a physiological basis for addiction, as well. This remains to be verified by future research.

Methadone treatment is helping many addicts function in ways they were not able to function while on street heroin alone, and certainly not while they were in prisons. Methadone may be preventing the death of some who without treatment would die of overdose or medical complications of unsterile injections.⁶ Also, methadone programs seem to make it possible for many addicts to stay out of jail. Whether one's concern is for the people affected, that is, the addicts, or whether one is concerned with cost (monetary, as well as to society), then the benefits of methadone treatment cannot be denied.

We would like to end this impact report by quoting a woman interviewed at West Oakland's Methadone Program. When asked what the benefits of a methadone program were, she replied, "for those who want to give it (heroin) up, methadone helps them; for those that don't, methadone holds them."

REFERENCES

¹D. X. Freedman and E. C. Senay, "Methadone Treatment of Heroin Addiction," Annual Review of Medicine, Vol. 24, 1973, pg. 153.

²Barry S. Brown, Ph.D., Gloris J. Benn, and Donald R. Jansen, M.A. "Methadone Maintenance: Some Client Opinions," The American Journal of Psychiatry, Vol. 132, 1975, pg. 623.

³John C. Ball, Ph.D., Harold Graff, M.D., and John J. Sheehan, Jr. "The Heroin Addicts' View of Methadone Maintenance," British J. of Addiction, Vol. 69, 1974, pg. 89.

⁴Brown, Benn, and Jansen, op.cit., pg. 626

⁵Avram Goldstein, "Heroin Addiction: Sequential Treatment Employing Pharmacologic Supports," Archives of General Psychiatry (In Press).

⁶Freedman and Senay, op.cit., pg. 161.

APPENDIX

1. Letter from Roger B. King, Chief, Substance Abuse Branch, Sacramento, authorizing the Office of Program Evaluation to study the Methadone Programs in Alameda County.
2. Copy of the Oath of Confidentiality. This form was signed by all team members and by the director of the Office of Program Evaluation.
3. Copy of the Consent to Release Information. This form was read by all clients just prior to the interview, and was signed by the client using the client's code number.
4. Client Data Form.

DEPARTMENT OF HEALTH

714 P STREET
SACRAMENTO, CALIFORNIA 95814



Phone: 322-6690

November 25, 1975

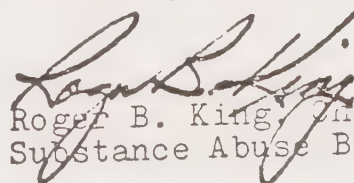
Shayna Stein
Office of Program Evaluation
Alameda County
1221 Oak Street, Suite 555
Oakland, CA 94612

Dear Mr. Stein:

The Office of Program Evaluation of Alameda County is hereby approved to conduct an evaluation of methadone programs in Alameda County. We have reviewed your and Nancy Jo Albers' curriculum vita and the Oaths of Confidentiality from all members of the drug evaluation team, and find them to be satisfactory.

A review of the study plan, however, raises some serious questions regarding certain proposed practices such as verifying past and present work histories, criminal activities and searches into other areas to obtain client data. We must remind you that your project is covered by all provisions of the Federal Regulations on Confidentiality of Alcohol and Drug Abuse Patient Records as published in the federal register July 1, 1975. Your activities are also covered by the Welfare and Institutions Code, Sections 5328 thru 5330. I recommend that you review the State and federal regulations and statutes with your county counsel before proceeding further.

Sincerely,


Roger B. King, Chief
Substance Abuse Branch

cc: David O'Dell, Director of Health Care Services
Susan Mandel, Director of Mental Health Services
Carl N. Lester, Alcohol and Drug Abuse Services
Rich Koppes, Legal, Department of Health

OATH OF CONFIDENTIALITY

Date

As a condition of doing research concerning persons who have received, or are receiving, services from Alameda County Mental Health Services, I, _____, agree not to divulge any information obtained in the course of such research to unauthorized persons, and not to publish or otherwise make public any information regarding persons who have received services such that the person who received services is identifiable. I recognize that unauthorized release of confidential information may make me subject to a civil action under Section 5330 of the Welfare and Institutions Code.

Signed

Purpose of The Drug Program Evaluation

The Drug Evaluation Team was established to determine the efficiency and effectiveness of various drug programs. Team members strongly believe that clients' views should be part of the evaluation process. Clients often have valuable suggestions to make on how services can be improved, even when they feel the program is working well.

Also, it is difficult to evaluate a program without knowing something about the people the program was established to help. What are their problems and needs, both past and present?

For these reasons, we ask your assistance in helping us in our study efforts.

Thank you.

Consent To Obtain and Release Information

The purposes of the evaluation of drug programs, as stated on the back of this form, have been explained to me.

I hereby grant representatives of the Office of Program Evaluation's Drug Evaluation Team the right to disclose information provided by me.

I understand that my name will never be used in any reports the Drug Team circulates. I give my permission for team members to obtain and release information on the basis that the identifying information will be held in strict confidence.

Code Number

Date

CLIENT DATA FORM

Date Completed: _____

Maintenance Program: _____

Date Client Entered Program: _____

Length of Stay in Program: _____

Current Status (successful termination, drop-out, dismissed, etc.): _____

R 1. :____: Age at last birthday?

R 2. :____: Sex Male = 0 Female = 1

R 3. :____: Race Black - 1 White = 2 Chicano = 3 Asian = 4 Other = 5

R 4. :____: Recode Race - Is client Black? No = 0 Yes = 1

R 5. :____: Last grade completed in school?

R 6. :____: Current marital status

1. Married
2. Never married
3. Separated
4. Divorced
5. Widowed
6. Other (specify: _____)

7. :____: Recode marital status - Is client now married? No = 0 Yes = 1

C 8. :____: Current living situation

1. Client lives alone
2. Client lives with family
3. Client lives with friend(s)
4. Client lives in boarding house
5. Other (specify: _____)

C 9. :____: Current employment status

1. Client has full-time job (35 hours or more weekly)
2. Client has part-time job (less than 35 hours per week)
3. Client picks up odd jobs
4. Client unemployed
5. Client enrolled in full-time employment training program
6. Other (specify: _____)

C 10. :____: How would client describe work history prior to admission to Methadone Program?

- 0 Had worked little or none (2 months or less)
1. Worked sporadically (odd jobs)
2. Worked steadily but not always full-time (seasonal)
3. Had fairly steady full-time employment.

C 11. : : : : Current total monthly gross income (specify source(s):)

R&C 12. : : : Number of previous out-patient admissions for methadone maintenance, regardless of program.

R&C 13. : : : : Number of previous admissions for drug treatment, excluding methadone maintenance.

R&C 14. : : Record source of referral for this admission.

1. Criminal justice

2. Other treatment program

3. Self

4. Family

5. Other (specify:)

R&C 15. : : Is client currently on probation or parole? No = 0 Yes = 1

R&C 16. : : Primary reason for choosing Methadone Program?

1. Alternative to pending incarceration

2. Tried other means and failed

3. Allows client to remain with family

4. Allows client to remain employed

5. Too much hassle getting heroin

6. Other (specify:)

R&C 17. : : : : Longest period of continued heroin use (months)?

R&C 18. : : : : How long ago (months) was heroin taken (if less than 15 days, record 000; if more than 15 days but less than 1 month, put 001)

R&C 19. : : : : Cost of habit by the average week in dollars.

R&C 20. : : : : Number of arrests for drugs 6 months prior to admission to Program?

R&C 21. : : : : Number of days in jail for drugs 6 months before admission to Program?

R&C 22. : : : : Number of arrests for property crimes 6 months prior to admission to Program?

R&C 23. : : : : Number of days in jail for property crimes 6 months before admission to Program?

Briefly describe history of criminal involvement for drugs and property crimes

R 24. Record all methadone dosage levels and dates of change since client's last admission to this program

R 25. Record all dirty urines by dates since client's last admission to this program _____

26. Record all dirty urines for barbiturates and amphetamines by dates since client's last admission to this program _____

R 27. Record number of one-to-one, group, family, and other discrete services, including vocational counseling, since last admission to this program _____

R&C 28. :____:____: Length of time (months) client has been in program since last admission date

C 29. Has client used any of the following during past month (place 0 to the left of the item if not, 1 to the left if yes)?

:____: Marijuana, has (approximate amount _____)

:____: LSD, other hallucinogens (approximate amount _____)

:____: Barbs, downers (approximate amount _____)

:____: Amphetamines, uppers (approximate amount _____)

:____: Alcohol (kind and amount _____)

:____: Other (specify: _____)

C 30. :____: Has client ever felt he/she ought to cut down on drinking?

No = 0 Yes = 1

C 31. :____: Has client ever been annoyed by people criticizing his/her drinking?

No = 0 Yes = 1

C 32. :____: Has client ever felt bad or guilty about his/her drinking?

No = 0 Yes = 1

C 33. :____: Has client ever had a drink first thing in the morning to steady nerves or get rid of hangover?

No = 0 Yes = 1

C 34. :____: Currently, how would client rate overall physical health?

1. Very good

2. Good _____

3. Fair

4. Poor

5. Very poor _____

If client gives any of these responses,
please record explanation

C 35. :___: Prior to this program admission, how would client rate overall physical health?

1. Very good
2. Good
3. Fair
4. Poor
5. Very poor

Again, explain

C 36. :___: Has taking Methadone in any way interfered with client's sexual functioning?

No = 0 Yes = 1 (specify: _____)

37. :___: Does client feel Methadone Maintenance has helped him feel better about himself in anyway?

No = 0 Yes = 1 (specify: _____)

C 38. :___: Just prior to program admission, how would client rate the quality of his/her personal relations with family?

1. Very good
2. Good
3. Fair
4. Poor
5. Very poor
6. NA, has no family

C 39. :___: At this time, how does client rate the quality of his/her relations with family?

1. Very good
2. Good
3. Fair
4. Poor
5. Very poor
6. NA, has no family

C 40. :___: Just prior to program admission, how would client rate the quality of his/her personal relations with friends?

1. Very good
2. Good
3. Fair
4. Poor
5. Very poor
6. NA, has no friends

C 41. :___: At this time, how does client rate the quality of his/her relations with friends?

1. Very good
2. Good
3. Fair
4. Poor
5. Very poor
6. NA, has no friends

C 42. : ____: Does client feel he should participate in decision-making process of how much Methadone he receives?

No = 0 Yes = 1

C 43. : ____: Does client feel he should be required to utilize counseling services to obtain Mathadone?

No = 0 Yes = 1

C 44. : ____: How would client rate attention given to medical needs?

1. Very good
2. Good
3. Fair
4. Poor
5. Very poor

C 45. : ____: How would client rate the quality of non-medical care (counseling, etc.) he/she has received in this program?

1. Very good
2. Good
3. Fair
4. Poor
5. Very poor
6. NA, none received

R&C 46. : ____: Number of times per week client is allowed to take Methadone home.

C 47. : ____: Is client satisfied with the hours that the program is open?

No = 0 (specify reasons: _____)

Yes = 1

C 48. : ____: Does client feel Methadone is a safe drug in terms of physical effects?

No = 0 Yes = 1

(if no, specify client's concerns: _____)

OTHER COMMENTS EITHER BY INTERVIEWER OR CLIENT: _____



METHADONE PROGRAM EFFICIENCY

TABLE OF CONTENTS

1. Methodology
2. Herrick's Methadone Program
3. West Oakland's Methadone Program
4. Eden's Methadone Program
5. East Oakland's Methadone Program
6. Overall Comparison of the Four Methadone Programs
7. Appendix

METHODOLOGY

Five methods were utilized to gather information about the four methadone programs in the efficiency evaluation. The first method was non-participant observation for a minimum period of five days to gather information which would permit systematic description of the activities of each program. The additional four were:

- staff interviews
- review of administrative and fiscal records
- review of the Methadone Maintenance Program Quarterly Report to the State, for the quarter ending September 30, 1975
- review of written responses by the programs to a questionnaire administered by the evaluator

Both quantitative and qualitative indices were selected to accurately reflect program efficiency. In the narrative about each program, the qualitative and quantitative data are reported in the following manner:

1. Facility
2. Approved, funded and filled slots
3. Average cost per clients per year based on current occupancy level
4. Age, Ethnicity, and Sex of client population
5. Program Objectives
6. Organizational Structure
7. Management
8. Personnel
9. Financial Management
10. Policies and Procedures
11. Conclusions
12. Recommendations

The quantitative indices and comparisons of each program are summarized in a final chapter. The indices include:

1. Unit cost per occupied slot per program per year based on current occupancy level
2. Percent of occupied slots to authorized slots
3. Unit cost per approved slot per program per year
4. Ratio of actual to standard budget
5. Staff - client ratio
6. Time spent in counseling activities
7. Counselor - client ratio

Limitations of the Study

Programs function so differently that adequate comparisons in some areas are almost impossible. For example, similar job titles in different programs may not indicate similar job functions. Psychiatrists at Herrick mainly perform psychiatric functions; whereas, at West Oakland, the psychiatrist performs psychiatric services and all of the physical examinations.

The amount of cooperation differed among programs so that the depth of information, especially in the qualitative areas, is different for each program. Moreover, the reliability and validity of information obtained from the programs' records must be taken with caution. Record-keeping was sometimes rather haphazard.

In general, the observations and information gathered were believed to permit an adequate efficiency evaluation of the programs.

HERRICK METHADONE PROGRAM (CONTRACT)

Facility

Herrick's program is located in Berkeley. The program has two service sites, one inside Herrick Hospital at 2001 Dwight Way and the other in a two-story, wooden frame house at 1925 Blake Street. Dispensing of methadone takes place within a small area of the hospital designated for the methadone program. A high degree of interaction between clients and staff takes place during dispensing hours, and this is facilitated by the limited size of the area. The house on Blake Street, which is about one block from the hospital, is used for some group therapy, one-to-one counseling, and office space.

Slots Approved, Funded, and Filled

Number of treatment slots approved	100
Number of treatment slots budgeted	100
Number of treatment slots currently filled	103
Number of clients on waiting list	25

*Source: Methadone Maintenance Program Quarterly Report to the State for period ending September 30, 1975.

The current occupancy level of 103 clients results in a yearly average cost per client of \$1,748. This figure is arrived at by dividing the program's budget of \$180,000 by the number of clients enrolled.

Age, Ethnicity, and Sex of Client Population

Age	White		Black		Mex-Amer.		Other		Total		Total
	M	F	M	F	M	F	M	F	M	F	
Under 21	0	0	0	0	0	0	0	0	0	0	0
21-25	4	10	10	4	2	1	2	0	18	15	33
26-35	24	6	16	2	2	3	2	1	44	12	56
36-45	0	2	8	0	1	1	0	0	9	3	12
46-65	0	0	1	1	0	0	0	0	1	1	2
Over 66	0	0	0	0	0	0	0	0	0	0	0
TOTAL	28	18	35	7	5	5	4	1	72	31	103

Source: Methadone Maintenance Program Quarterly Report for period ending September 30, 1975. Report is prepared by the program for submission to the State of California, Department of Health.

Program Objectives

The objectives of the program, as well as the services offered, are clearly stated in written form. The major goal of treatment is to help clients stop using illicit chemicals and other drugs.

Herrick's program maintains agreements with other health and drug-related programs to meet some of its program objectives. For example, Herrick's program maintains a contract with Alta Bates Hospital for clinical laboratory tests and with the West Berkeley Health Center for client physical examinations. These contracts, as well as others, are developed, periodically updated and approved by the governing body of Herrick Hospital.

Organizational Structure

Herrick is organized to effectively implement the objectives of the methadone program. The program operates under the direction of the hospital which has full legal authority and responsibility for the overall conduct of the program. The governing body of the hospital establishes policy to ensure the accountability of the program's medical staff and other personnel. The governing body is responsible to the population served by the program.

The channels of responsibility, as well as supervisory relationships, within the methadone program have been documented by means of an organizational chart. Administrative records and reports are maintained which reflect the operation of the program. Overall, the organizational structure is excellent. (see organizational chart at the end of this section)

Management

During the evaluation site visit the hospital promoted the methadone program supervisor to program director. His selection is only a formal affirmation of the position he has occupied since the inception of the program in 1971. The new director participated in a year long management development program conducted by the Holloway, Hecht, Hacker and Boldy, Inc., management consultants to the hospital. The purpose of the management program was to prepare the director to assure his new responsibilities.

Management of the methadone program is well coordinated and individual responsibilities are clearly defined, with authority appropriately delegated to insure adequate decisions. The management invites comments from all people with knowledge of problems, and solutions are usually achieved by a consensus model.

The Herrick program has an effective Patient Council to assist in providing input to the program. The program also has an excellent staff communication and weekly case conference system.

Personnel

There are a total of five full-time and three part-time staff persons at Herrick's Program:

Walter Byrd	Director
Geraldine Fink	Medical Director (PT) - provides some counseling services
J. Patrick Adamson	Physician (PT) - provides some counseling services
Vivian Kaufman	Registered Nurse
Mary Ellis	Registered Nurse (PT)
Robert World	Counselor
Jake Page	Counselor
Mildred Moore	Clerk - Counselor Trainee

Staffing is adequate to provide the services essential to implement the objectives of the program. Moreover, Herrick has exactly the number of counselors (3.5) that is recommended by the State for a client enrollment of 100. Although the number of staff persons is considered adequate, additional female staff time could assist in meeting the expressed needs of the female clients.

Staff - client ratios:

Based on information furnished by the program, the following ratios were computed:

Staff - client ratio	1 to 17.6
Counseling personnel - client ratio	1 to 29.4

Counseling Productivity:

For a detailed description of how counseling productivity is arrived at, please refer to the last chapter in this section.

Herrick's counselors perform the following activities: intake screening, urine

surveillance, counseling, record-keeping, attend staff meetings and case conferences, answer correspondence, make referrals and conduct follow-up, plan treatment, and engage in collaboration with other staff members and community agencies. For the quarterly period ending September 30, 1975, Herrick's counselors spent 40 percent of their available time in counseling. An in-depth analysis of manpower utilization within Herrick's program would be required in order to make judgments about the adequacy of time spent providing counseling.

Staff Training

Training and educational opportunities for staff are limited. Part of this situation is created by the lack of funds. To facilitate the development of all staff, a continuing education and in-service training program should be developed. Despite the lack of in-service training, staff morale is high and staff turnover has been non-existent since the inception of the program.

Financial Management

A budget related to the program's objectives is developed annually with the participation of appropriate hospital staff. The annual hospital budget hearings were being conducted at the time of this evaluation.

The hospital maintains adequate financial records. The accounting system produces timely information reflecting the fiscal experience and the current financial position of the program.

Policies and Procedures (refer to the end of this section for a detailed listing of the program's procedures)

Policies and procedures have been developed for the effective implementation of the program's objectives. The policies have been administered more consistently than in any other program. Time-specific service hours are maintained with no exceptions. The methadone dispensing clinic opens and closes promptly.

The hours are as follows:

Monday through Friday	6:00 a.m. - 8:30 a.m.
Saturday and Sunday	9:00 a.m. - 11:00 a.m.

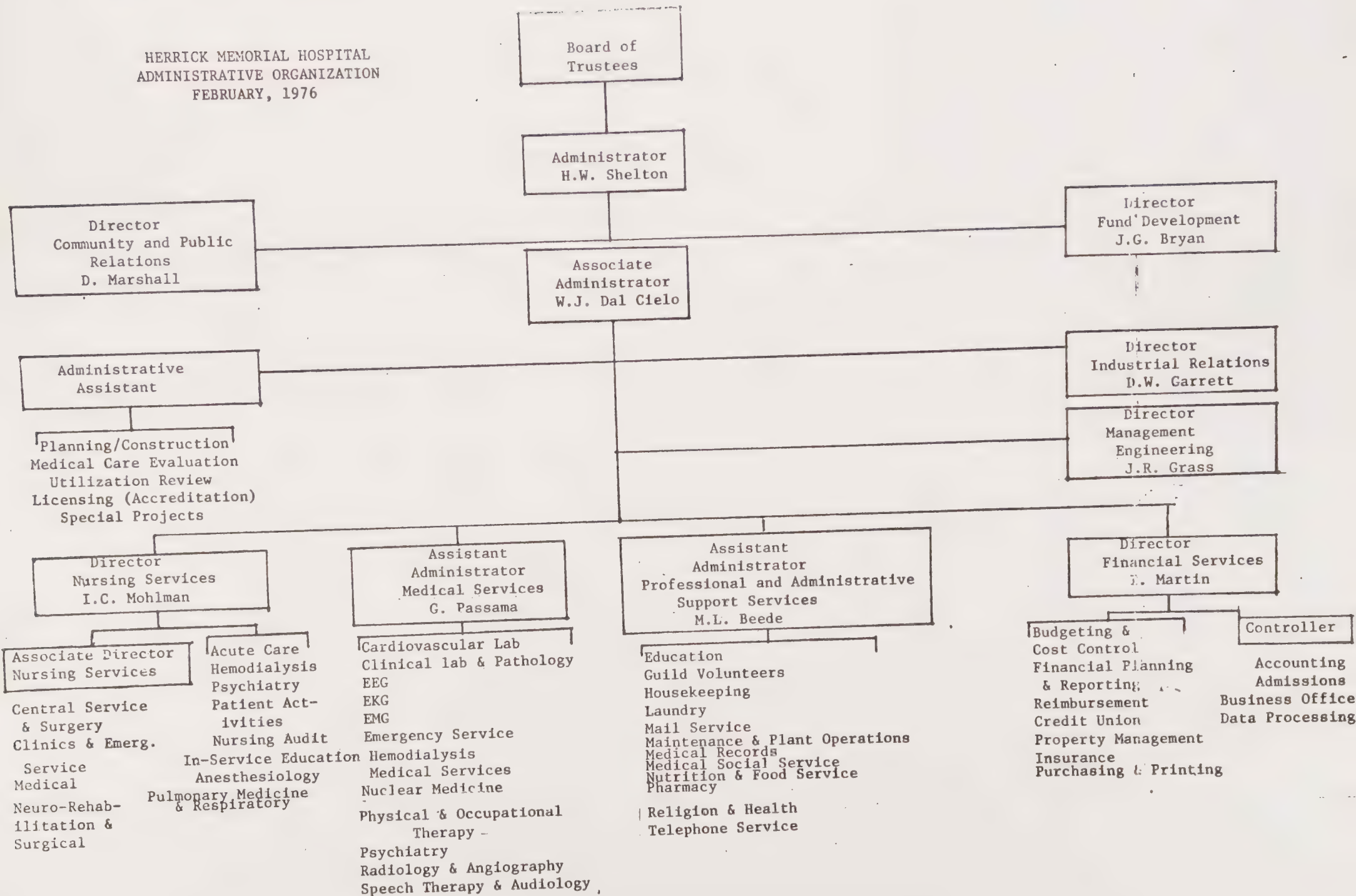
Conclusions

Herrick's Methadone Program is an excellent program staffed by dedicated professionals and managed very efficiently.

Recommendations

1. Provision of additional female staff time could assist in meeting the expressed needs of female clients.
2. Development of an inservice training program for all classifications of employees would enhance the professional growth of the staff.

HERRICK MEMORIAL HOSPITAL
ADMINISTRATIVE ORGANIZATION
FEBRUARY, 1976



HERRICK-BERKELEY COMMUNITY METHADONE PROGRAM

ORGANIZATIONAL STRUCTURE

HERRICK MEMORIAL HOSPITAL BOARD OF DIRECTORS

ADMINISTRATOR

Mr. Hershel Shelton

HERRICK MEMORIAL HOSPITAL MEDICAL BOARD

ASSISTANT ADMINISTRATOR

Mr. Gary Passama

DEPARTMENT OF PSYCHIATRY
CHIEF AND DIRECTOR

Drs. Marvin Wolff and William Sheehy

DIRECTOR

Mr. Walter Byrd

MEDICAL DIRECTOR

Dr. Geraldine Fink

NURSES

PHYSICIANS

COUNSELORS

CLERICAL

Information and Rules

CLINIC HOURS:

Mondays through Fridays: 6:00 a.m. to 8:30 a.m.

Saturdays, Sundays & Holidays (when posted): 9:00 a.m. to 11:30 a.m.

IF YOU DON'T GET TO THE CLINIC WITHIN THESE HOURS, WITHOUT PRIOR PERMISSION, YOU WILL NOT RECEIVE YOUR MEDICATION. YOU WILL GET BETTER SERVICE IF YOU DON'T WAIT UNTIL THE LAST MINUTE TO COME TO THE CLINIC. AND, YOU WILL ALSO AVOID THE RISK OF MISSING YOUR MEDICATION BECAUSE OF A LAST-MINUTE DELAY, FLAT TIRE, ETCETERA. DISCUSS ANY SPECIAL PROBLEMS WITH US A FEW DAYS AHEAD OF TIME AND PERHAPS WE CAN WORK SOMETHING OUT.

URINE TESTING:

Always come into the clinic prepared to give a urine sample if requested. A list is posted every day. If your name is on the list, you are required to give a urine sample that day. Refusal to give a urine sample, or not being able to give a large enough sample, is counted automatically as a positive (DIRTY) urine.***On the third day, you will not receive your medication: NO URINE, NO METHADONE. All urine samples must be given under direct supervision of a staff member.

Also, if you are ever absent from the clinic without authorization, you will have to give a urine sample the day you return. If you do not give a urine sample, you will receive a positive (DIRTY) urine. By the third day, if you still have not given a urine sample, you will not receive your medication until you do so.

PROGRESS EVALUATIONS:

The progress of patients toward complete rehabilitation will be followed by an orderly system of interviews with the staff. Patients are expected to cooperate in keeping appointments for interviews. Group attendance will also be recommended or required.

STEPS OF RESPONSIBILITY FOR TAKING METHADONE HOME:

These are the general rules, but the actual decision is made by the staff in each case, in the best interest of the program and the individual patient. In addition to being 'clean', other criteria for being considered for take-home privileges are that a person is working, attending school, and/or a housewife, up to date on his/her fees, and involved in counselling (Group or Individual).

- Step 1. Daily clinic attendance, 7 days a week
- Step 2. Three months clean, one day's take-home
- Step 3. Six months clean, two days' take-home

PLEASE REMEMBER TO BRING BACK THE EMPTY BOTTLE(S) UPON YOUR RETURN TO THE CLINIC.

(*** In some instances, you will be allowed to return later in the day to give a urine specimen.)

BERKELEY COMMUNITY METHADONE PROGRAM

PROCEDURE FOR URINE TESTING
(Approved by Staff)

From: PATIENT COUNCIL

FOR PERSONS WHO WORK:

1. Must get here in time to try to give a urine specimen for at least five (5) minutes.
***If patient cannot urinate, he will still receive his Methadone, plus an automatic dirty.
2. On the second day, if patient cannot urinate, he will receive his Methadone, plus an automatic dirty.
***If he comes back later in the day, and gives a urine specimen, the automatic dirty will be removed.
3. On the third day, if patient still gives no urine specimen, he will not receive his Methadone.

FOR PERSON WHO DO NOT WORK:

1. On the first day of testing, patient must try to give a urine specimen until 8:30 a.m., in order to receive his Methadone.
2. Same as item #2 for persons who work.
3. Same as item #3 for persons who work.

ANYONE CAUGHT CHEATING IN GIVING A URINE SPECIMEN WILL BE DEALT
WITH IN THE SAME MANNER AS HAVING HAD TOO MANY DIRTIES

ABSENCES:

Patients absent from the clinic a day or more, must upon their return, give a urine specimen or receive an automatic dirty before receiving their Methadone.
***If the patient who is unable to give a urine specimen returns later that day, and gives a urine specimen, the automatic dirty will be removed.

STEPPING BACK:

If a patient who has take-home privileges, uses drugs or fails to give a urine sample upon request, he may lose his take-home privileges. One who fails to give a urine sample upon request, will receive a positive (DIRTY) urine. Also, if a patient who has take-home privileges, misses a clinic appointment he will go back one step for that week.

If a patient has reached any step beyond Step 1, and uses, he will go back to the previous step. He will be able to advance again after remaining clean for the usual time required at that step. Within two years of starting the program, all patients will be considered for withdrawal from Methadone.

DOSE CHANGE:

Anyone wishing to have their dose lowered, must be clean for at least thirty (30) days. Anyone wishing to have their dose lowered from their maintenance dose to a comfort dose, must attend counselling sessions. Patients desiring a slow detoxification, must attend the Detoxification Groups.

RETURNING AFTER AN ABSENCE:

When a patient returns to the program after a period of suspension, he will start again at Step 1 (daily clinic attendance). When a patient returns to regular status after being in the hospital or in jail, the staff will review his situation to determine what step he should be on for take-home medication.

PATIENT COUNCIL:

A Patient Council can be formed to represent the patients in all matters concerning them. The names of the Council members are posted on the bulletin board. Bring any non-medical problems or complaints to the Council. Help the Council in its work. Take more responsibility for the program -- It is Yours. Think about how we can give other addicts the same kind of help you have received.

SUSPENSIONS AND DISCHARGES:

If a patient is suspended or discharged from the program, as described below, he may first attend clinic daily for fifteen (15) days to have his dosage reduced to zero (0).

A patient will be suspended for thirty (30) days:

- if he is absent four (4) days in a single calendar month without advance authorization.
- if he fails to respect a summons to appear before the Patient Council, or fails to abide by a staff decision resulting from a recommendation of the Patient Council.
- if staff decides, after careful consideration, that a temporary suspension would be useful therapeutically, in improving his motivation or behavior.

SUSPENSIONS AND DISCHARGES: (continued from page 2)

A patient who is suspended is still considered to be on the program; the suspension is a therapeutic measure, part of the confidential medical records of the clinic.

A patient will be discharged from the program if his actions endanger the program, and specifically:

- if he uses or threatens to use physical violence against any staff member or patient.
- if he gives away or sells Methadone to any other person.
- if he sells, gives away, buys, possesses, or uses any illicit drug in the clinic, the House (1975 Blake St.) or their vicinity.

He will also be discharged automatically if he has missed appointments for two weeks. A patient who has been discharged and wishes to re-enter the program will be placed on the waiting list; he will be admitted only if staff decides this would not endanger the program.

RESPONSIBILITY FOR METHADONE:

Methadone is dangerous to those not already used to it, especially to children, who could easily be killed by it. If our Methadone finds its way to such people, the program will also be in danger. To protect innocent people and to protect the program, we must not let anything like that happen.

YOU are responsible for the security of the Methadone you take home. If you cannot protect it against loss or theft, then you cannot take it home at all. Therefore, if your Methadone is lost or stolen, you will be dropped back immediately to step 1 (daily clinic attendance).

The locked box is an absolute rule. No Methadone will leave the clinic except in your own locked box, with an adequate lock, and the key in your possession. Not someone's borrowed box. Not the glove compartment of your car. It is YOUR responsibility to get a proper locked box and to bring it with you.

Methadone should stay in the locked box always. DO NOT REFRIGERATE. It is not necessary. Methadone will not spoil. The refrigerator is the most dangerous place you could think of to put your Methadone. Keep the locked box hidden and secure. It is YOUR responsibility. IF YOUR METHADONE IS LOST OR STOLEN, IT WILL NOT BE REPLACED.

CONSTIPATION:

This is one of the troublesome things about Methadone. Use a stool softener like Metamucil which you can buy in large quantities at the drugstore. Use it regularly every day. Try not to use laxatives, which only upset your system. It is all right if you move your bowels only once or twice a week. If necessary, take an enema once a week. As long as you keep it soft, you won't be hurting yourself. Prunes are also helpful.

EMERGENCIES:

CLINIC -- 845-0130, ext. 487

"HOUSE" (1975 Blake St.) -- 845-0130, ext. 318 & 476

WEST OAKLAND METHADONE PROGRAM (CONTRACT)

Facility

West Oakland's Methadone Program is located at 688 7th Street. Formerly a commercial facility, the building in which the program is housed has been renovated to provide office space. Space is ample, and room exists to partition more offices, if necessary.

The internal and external environment is rather dismal, except for a few offices that have been made comfortable by the staff persons who use them. Many of the program's clients spend their time on the sidewalk in front of the program. The client waiting area is large, yet almost barren, except for a pool table and methadone dispensing station. Housekeeping is poor. Inadequate funding and difficulties over a union labor contract were cited by management as obstacles to obtaining adequate housekeeping and janitorial services.

Slots Approved, Funded, and Filled

Number of treatment slots approved	300
Number of treatment slots budgeted	200
Number of treatment slots currently filled	185
Number of clients on waiting list	31

The current occupancy level of 185 clients results in a yearly average cost per client of \$1,642. This figure is arrived at by dividing the program's budget of \$303,733 by the number of clients enrolled.

Age, Ethnicity, and Sex of Client Population

Age	White		Black		Mex-Amer.		Other		Total		Total
	M	F	M	F	M	F	M	F	M	F	
Under 21	0	0	0	0	0	0	0	0	0	0	0
21-25	4	8	10	7	2	1	2	0	18	16	34
26-35	8	2	33	15	7	3	1	0	49	20	69
36-45	6	1	31	10	6	2	1	0	44	13	57
46-65	3	0	13	6	1	0	0	0	17	6	23
Over 66	2	0	0	0	0	0	0	0	2	0	2
TOTAL	23	11	87	38	16	6	4	0	130	55	185

Source: Methadone Maintenance Program Quarterly Report for period ending September 30, 1975. Report is prepared by the Program for submission to the State of California, Department of Health.

Personnel

During the evaluation site visit, there were a total of 15 full-time and four part-time staff persons.

Isaac Slaughter	Medical Director (PT)
Vacant during site visit	Physician
Tom Joynter	Coordinator of Treatment (PT)
Wilma Brown	Coordinator of Administrative Operations (PT)
Elmer Franklin	Chief Psychiatric Social Worker - Director of Drug Abuse Services (provides counseling)
Len Harris	Psychiatric Social Worker
Gail Valentine	Psychiatric Social Worker
James Sessoms	Psychiatric Social Worker
Cheryl Washington	Chief Nurse
Pat Turner	LVN
Paulette Dulan	LVN
Ellen Houston	LVN
Reyla Jenkins	LVN
Moses McClain	Senior Mental Health Specialist
Marsha Luster	Mental Health Specialist
Joyce Riley	Mental Health Specialist
Ralph Garcia	Mental Health Specialist
Lowell Yamashita	Account (PT)
Irene Washington	Clerk Typist
Vacant during site visit	Administrative Assistant/Secretary (PT)

The program had more than a sufficient number of personnel to meet the needs of clients. According to State recommendations, West Oakland's program should have a minimum of 6.7 counselors, and the program had eight counselors during the site visit. The program had a total of five nurses, (State recommends a minimum of three) but might be able to function effectively with four nurses if the dispensing hours were shortened. Methadone is dispensed from 7:00 a.m. to 2:00 a.m., Monday through Friday and by special permission from 4:00 p.m. to 5:00 p.m. On Saturdays, Sundays, and holidays, dispensing takes place from 7:30 a.m. to 9:30 a.m. West Oakland's program has the longest weekly dispensing hours of any of the methadone programs studied. There is nothing inherent in the treatment population to suggest a need for such long dispensing hours, and reduction in nursing coverage would make the program more cost efficient.

Based on information furnished by the program, the following ratios were computed:

Staff - client ratio	= 1 to 11.3
Counseling personnel - client ratio	= 1 to 23.1

Program Objectives

The objectives and eligibility criteria of the program are formulated and clearly stated in written form.

The program has agreements for the procurement of necessary consultation and health services. These agreements are primarily with the West Oakland Health Center, and are periodically updated and approved by the Health Center Director and the Mental Health Director.

Organizational Structure (refer to the end of this section for the organizational chart)

West Oakland has an organizational chart available that clearly illustrates the lines of authority. The methadone program is under mental health services of the West Oakland Health Center. Legal and overall responsibility for the methadone program rests with the Board of Directors. They are responsible for policy; However, the organizational chart does not fix authority within the methadone program.

Administrative records and reports are maintained and used. The methadone program receives many support services from the parent Health Center; however, evidence was present that friction exists between Health Center and methadone personnel. The source appears to be conflict over the amount of autonomy the methadone operation should have from Health Center policies in personnel matters and approval of fiscal expenditures. Regardless of the merits of either side's argument, some joint activity between representatives of the West Oakland Health Center and the Methadone Program is necessary to resolve current conflicts.

Management

Responsibility for the methadone program is delegated by the Mental Health Director of West Oakland's Health Center to a Chief Psychiatric Social Worker. However, the delegation appears to be incomplete as perceived by the methadone program staff and clients. Part of the confusion is possibly created by the role of the Mental Health Director as the "part-time" Medical Director of the methadone program. Since he has been with the methadone program from its inception, it appears only natural that staff and clients would continue to relate to him as the actual director.

During the evaluation site visit, the nursing unit at West Oakland seemed to function autonomously of the other program staff. Also, on several occasions, the evaluator observed nurses responding to clients in arbitrary ways over dispensing of methadone. It further appeared that some nurses utilized the periodic urine tests as a punitive measure toward clients not conforming to their expectations. To give examples of these points, the following observations are provided: the evaluator was present when a client arrived at the dispensing station approximately thirty minutes before closing. The client was informed that a urine was required for that day. Being unable to void right away, the client remained in the waiting area until such time as she was able to void.

Management (continued)

Unfortunately, she found she was able to void fifteen minutes after dispensing hours were over. The nurse refused to give the client methadone for the day or to accept a urine. The client's counselor attempted to intercede with the nurse, but was unsuccessful. The counselor and the client tried to reach the Mental Health Director at the West Oakland Health Center in order to settle the dispute. Unable to speak with the Mental Health Director or other administrative personnel at the Health Center, the counselor and the client then accidentally came to the attention of the Director of Drug Abuse Services within the methadone program. Eventually, the client received methadone for the day, but this did not erase the tensions between nursing and clinical personnel. On another occasion, the evaluator observed a client experiencing some conflict with a nurse over dispensing procedures. After the nurse and client's discussion ended, the nurse stated to the evaluator that she would "fix the guy." She said she would require the client to give urines for the next several days.

If the program is to function in an integrated way, conflicts that arise within the team process will ultimately have to be solved by the Director of Drug Abuse Services. Also, the right of clients to make their grievances known can be severely restricted if the urines are administered by the nurses as a punitive measure, rather than as a clinical tool. This should be corrected.

The program appeared to have adequate written procedures; however, consistent enforcement is almost nonexistent with regard to certain client behavior on the premises. Clients were observed by the evaluator to drink alcoholic beverages on the premises with complete immunity. When the nursing personnel were asked by the evaluator who was responsible for enforcement of rules concerning clients' drinking, they acknowledged that they were responsible. However, fear of physical reprisals was offered as the reason for nonenforcement of this policy. It appears that the nursing personnel have clearly demonstrated that they are incapable of accepting responsibility and authority for certain program policies.

Counseling Productivity

For a detailed description of how counseling productivity is arrived at, refer to the chapter in which all four methadone programs are compared.

West Oakland's counselors perform the following activities: intake screening, urine surveillance, counseling, recordkeeping, attend staff meetings and case conferences, answer correspondence, make referrals and conduct follow-up, plan treatment, and engage in collaboration with other staff members and community agencies. For the quarterly period ending September 30, 1975, West Oakland's counselors spent 23 percent of their available time delivering counseling services. An in-depth analysis of manpower utilization within West Oakland's program would be required in order to make judgments about the adequacy of time spent providing counseling. However, this figure is the lowest of all four methadone programs.

Staff Training

West Oakland's Health Center has a full-time health training coordinator. This enables the methadone program staff to participate in educational and training activities both within the Health Center and other community institutions of higher education. Many of the lecturers in the training program are Psychiatric Social Workers from the West Oakland staff, and this offers the trainees an excellent opportunity to make the difficult transition from the classroom to the clinical setting.

All of the staff of the Mental Health Division of the West Oakland Health Center are available to the methadone program for in-service training. This is especially beneficial for staff members who are not participating in a continuing education program. The extent of staff training at West Oakland far surpasses that of any other methadone program studied. These training functions also facilitate the upward and lateral mobility of staff.

Financial Management

The financial records for the methadone program are maintained by the accounting department of the West Oakland Health Center. The service provided seems to be adequate, however, there are some problems over contract interpretation. Recently, the methadone program failed to receive prior written approval from the County or the State for the transfer of funds from one budgetary category to another. As a result, there was approximately a \$4,000 disallowance for certain expenditures. This situation has created conflict between the methadone program and the Health Center.

Policies and Procedures (refer to the end of this section for a specific listing)

West Oakland has policies and procedures to implement the objectives of the program. However, enforcement is inconsistent, as has already been pointed out.

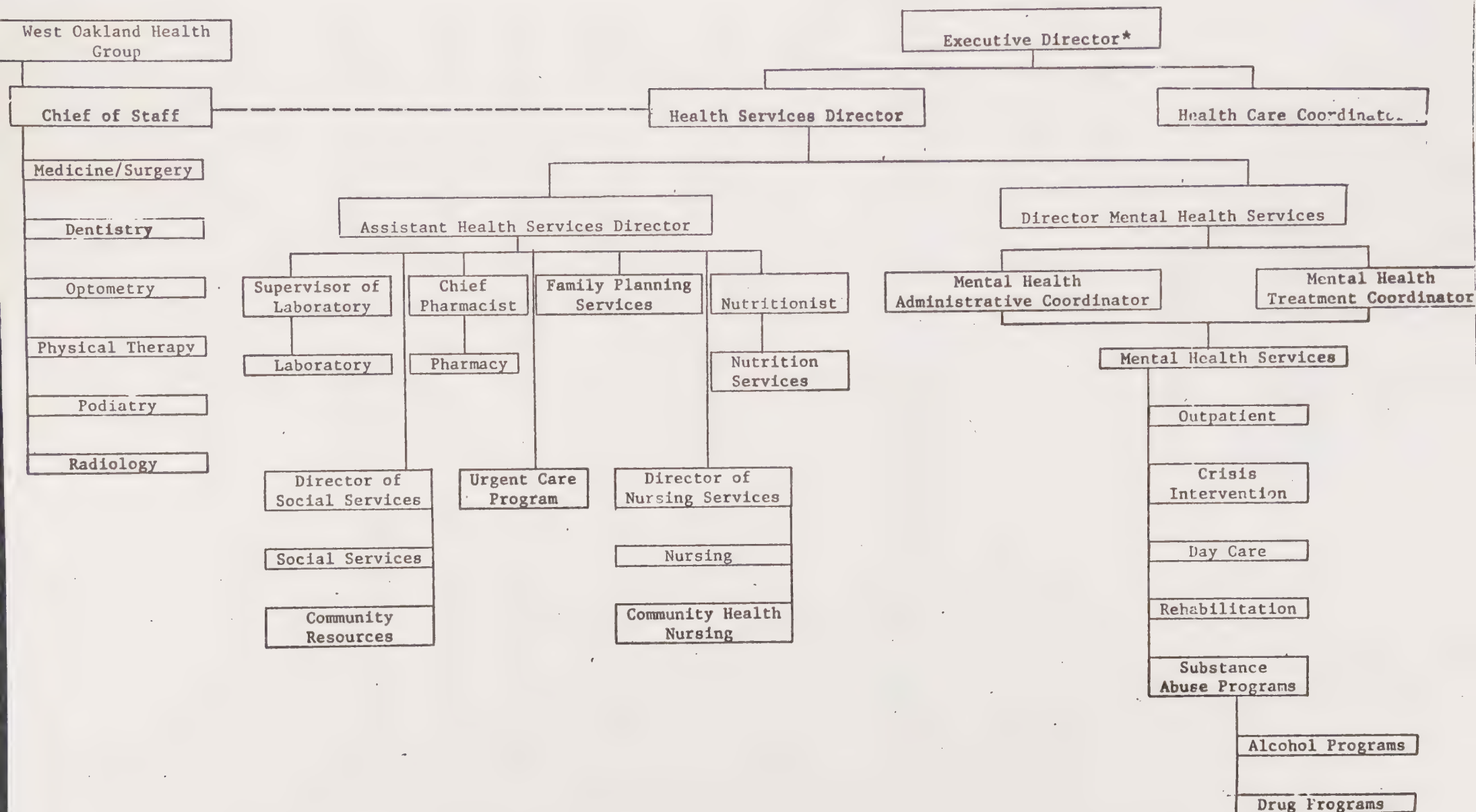
Conclusions

With all of the resources that West Oakland's Methadone Program has at its disposal, administrative problems tend to command one's attention. On the positive side, West Oakland has an outspoken advocate of mental health services for minority and disadvantaged people, has the largest funding base, the capacity to provide the most complete services to clients within its own program structure, and the most complete training program. However, conflicts over responsibility and authority for program management have undermined the program's ability to provide the best possible services to the clients.

Recommendations

1. Establish an intergroup work program which increases the collaboration and decreases the competition between nursing and counseling personnel.
2. Delegate all methadone maintenance program operating decisions to the Director of Drug Abuse Services.
3. Establish a program of client participation in program affairs, e.g., client advisory board or patient council.
4. Enforce program guidelines concerning client behavior in all aspects of the program.
5. Establish controls to insure that expenditures are within the budget categories authorized by the funding agency.
6. Provision of housekeeping/janitorial services.
7. There should be some joint activity between representatives of the West Oakland Health Center and representatives of West Oakland's Methadone Program to work on critical issues, i.e., personnel, fiscal, and administrative services.

WEST OAKLAND HEALTH CENTER - HEALTH CARE SERVICES



Responsible to West Oakland Health Council, Inc. Board of Directors

WEST OAKLAND HEALTH CENTER
METHADONE MAINTENANCE PROGRAM

PARTICIPANT FACT SHEET

I. DISPENSING HOURS

Monday - Friday	7:00 a.m. - 2:00 p.m.
(By special permission only)	4:00 p.m. - 5:00 p.m.
Saturdays, Sundays, & Holidays	7:30 a.m. - 9:30 a.m.

The above hours are regular medication hours. If you are late you will not receive you medication. On rare and special occasions the above hours might change. These changes will be posted in advance and each participant will be aware of the change.

II. DAILY PROCEDURE

1. You will be required to give a urine specimen upon request at each clinic visit. Be Prepared.
2. On those days you are required to give a specimen,
 - a. Give your ID card to this staff person who will give you a container in the bathroom.
3. Any attempt to substitute another urine for a fresh voided specimen or any other tampering with the urine specimen will result in NO MEDICATION FOR THE DAY.
4. After giving your urine specimen, return to the nurses' station to receive your medication. Your ID card will be returned to you with your medication.
5. You may discuss any discomforts from the medication with the nurse or other staff present.
6. If you have been put on any other medication by an outside physician, bring your prescription container with the medication in it into the clinic for recording by the nursing staff.

III. RULES AND REGULATIONS

1. You will be required to submit a urine sample upon request. Be Prepared. Failure to void on assigned days will result in a dirty urine. Failure to urinate will result in no medication for the day.
2. A participant must show his ID card before he receives his dosage of medication. If you do not have your card, a fee of \$2.00 is charged for a new card. The following day, a picture MUST be brought in to make the new card, or NO MEDICATION WILL BE DISPENSED.
3. If ill and unable to come to the clinic, the participant must give proof of being under a doctor's care. Verification and approval will be obtained by the nurse before MEDICATION WILL BE DELIVERED.
4. If you must be absent for any reason other than illness, you must arranged in advance with the clinic staff for that absence. If this is not done, you will be considered dirty for those absent days.
5. If you fail to get to the clinic during dispensing hours, you will not receive your medication. A LATE IS CONSIDERED AN ABSENCE. AN ABSENCE IS CONSIDERED A DIRTY.
6. Should you become incarcerated in Alameda County while you are on the program, you will either be placed on a withdrawal schedule, or maintained on your daily medication dosage at the discretion of the Medical Director. An exception to this is Santa Rita Rehabilitation Center, in which case your mode of treatment will be determined by the staff there.
7. Should you become incarcerated outside of Alameda County, the program will not guarantee continued treatment, but will make efforts to cover for a short-term incarceration.
8. Every participant in the WOHM Methadone Program will attend a least one group session per week.
 - a) THE STAFF MEMBER - leader of the group will be responsible for keeping record of your attendance, and it is the responsibility of the participants to make sure that his or her name is checked by that staff member at each group meeting.
 - b) All absences from group, excused or unexcused, must be made up by scheduling a counseling session with the group leader before the next scheduled group meeting.
 - c) DETOX from the program will be initiated if groups are not made up. This means you will be suspended from the program for 30 after a 3 weeks detox.

9. Every participant in the WOHC Methadone Program will pay a fee to help cover the cost of your urine being examined by the lab. Fees are based on a sliding scale according to ability to pay. You must arrange for payment of these fee with the Clerk.
- a) Non payment of the fee might be cause for detox from the program.
 - b) You are to pay this fee to the Clerk or other designated staff member, who will give you a receipt for your record.
10. To qualify for take home privileges, a participant must:
- 1) Be on the program for 90 days (3months)
 - 2) Have clean - drug - free urine specimen for 90 days
 - 3) Have no unauthorized absences
 - 4) Participation in program activities, especially weekly group. Payment of fees.
11. To qualify for added take home privileges you must have:
- 1) Adhered to all parts of Rule 10
 - 2) Been on the program for one year
 - 3) Made the take home list for a total of 9 months .
 - 4) Had no suspensions during the past three months
12. Any participant on week-end take home who comes up dirty (including assumed dirties for unauthorized absences), shall lose his take home privilege for one month, during which time he must stay clean and participate in program activities.
13. Any participant on twice a week take-home, who comes up dirty, (including assumed dirties for unauthorized absences), will return to weekend take home only, for a period of three months before your added take home privileges are returned. If you are suspended from take home completely for another dirty, you must wait one month before returning to weekend take home AND THREE additional months before returning to extended take home pribileges. If you have question see your counselor.

IV. POLICY ON DIRTIES

If you are one of thos participants who, while receiving the benefits of methadone, continue to use HEROIN - READ THE FOLLOWING CAREFULLY.

- 1. Those participants who have confirmed dirty urines (Morphine, Heroin,) twice or more in a 30 day period will have their methadone dosage decreased. This will allow for the presence of the two narcotics in the system at the same time.

2. Those participants who have confirmed dirty urines twice or more in a 30 day period, and continue to remain dirty for 60, 90, and 120 days, will have their dosage of methadone reduced over each 30 day period.
3. Methadone dosages will not be raised until a participant has been clean for at least 30 days.
4. Absences will continue to be considered as dirty urines, and failure to urinate on assigned days will result in a dirty urine. Failure to urinate will result in no medication for the day.

V. CAUSES FOR SUSPENSION

- A. Four or more days unauthorized absence in any calendar month. 1 MONTH
If the 4 days are consecutive suspension shall be without detox.
- B. Any attempt to take unswallowed methadone away from the dispensing counter or any attempt to sell or give away methadone. 1 YEAR
- C. Any participant observed drinking alcohol on premises will be reprimanded. Three reprimands in a 30 day period shall be cause for suspension.
- D. Attempted use, selling, possession or giving away of any illicit drug in the clinic or its vicinity. 1 YEAR
- E. Any selling of or bringing into the clinic or its vicinity, stolen property. 3 MONTHS
- F. Fighting and/or brandishing of weapons in the clinic area. 1 MONTH

Any participant who is suspended from the program must reapply to the program and be placed at the bottom of the current waiting list.

Any participant who does not return within 10 days of last date of the suspension period must go through a screening process.

Any participant who is suspended twice, in 6 months must reapply to the program at the end of his 2nd suspension period. Must go through screening process and may or may not be returned to the program.

VI. NOTICE OF IMPENDING DETOX

WOHC Methadone Program rules mandate that each participant, attend at least on group session per week.

As of this date, you have missed a group meeting. This is to notify you that if you do not make up this group before the next scheduled group meeting, DETOX from the program will be initiated immediately. This means you will be suspended from the program for 30 days after DETOX.

VII. POLICY ON TRANSFERS

1. If you need to transfer to another methadone program permanently you must go and apply at the program of your choice. Your group leader is responsible for sending your records and making sure your transfer goes through. If you cannot apply in person because it is out of the Bay Area, your worker will try to arrange the transfer for you. You must give at least 2 weeks notice of this transfer. Most programs have waiting lists plus they need to review your records. You may have to go through their screening committee.
2. If you need a temporary transfer to another methadone program up to 14 days you must give 2 weeks notice to the Chief Psychiatric Social Worker you must state the reason for your transfer and you must give an address where you can be reached where you are going. If you need a travelling dosage you will have to get approval directly from the Staff Psychiatrist. In all cases of temporary transfer, you must carry a letter of introduction to be presented at the program taking care of you during your visit. You will be expected to carry yourself well as a representative of the West Oakland Health Center Methadone Maintenance Program. Don't wait until the last minute to tell us about your trip. Give us at least 2 weeks notice or your trip may be delayed, especially if it is out of state.

EDEN METHADONE TREATMENT PROGRAM (COUNTY)

Facility

The program is located in the former County Public Health Clinic building at 15400 Foothill Boulevard. The facility is inadequate, with small offices, limited space, and poor layout. The layout inhibits the smooth flow of clients and reduces the opportunity for interaction between staff and clients. Also, inadequate facilities are a deterrent to monitoring of urine collections.

Slots Approved, Funded, and Filled

Number of treatment slots approved	150
Number of treatment slots budgeted	150
Number of treatment slots currently filled	145
Number of clients on waiting list	20

*Source: Methadone Maintenance Program quarterly report to the State for the period ending September 30, 1975.

The current occupancy level of 145 clients results in a yearly average cost per client of \$1,893. This figure is arrived at by dividing the program's budget of \$274,446 by the number of clients enrolled.

Age, Ethnicity, and Sex of Client Population

Age	White		Black		Mex.-Amer.		Other		Total		Total
	M	F	M	F	M	F	M	F	M	F	
Under 21	0	0	0	0	0	0	0	0	0	0	0
21-25	15	7	1	0	4	1	0	0	20	8	28
26-35	44	19	1	1	9	3	1	0	55	23	78
36-45	16	1	1	0	13	2	1	2	31	5	36
46-65	2	0	1	0	0	0	0	0	3	0	3
Over 66	0	0	0	0	0	0	0	0	0	0	0
TOTAL	77	27	4	1	26	6	2	2	109	36	145

Source: Methadone Maintenance Program Quarterly Report for period ending September 30, 1975. Report is prepared by the program for submission to the State of California, Department of Health.

Program Objectives

The programs' objectives and eligibility criteria are formulated and clearly stated in written documents appropriate for distribution. They appear to be active concepts in the administration of the programs and are applied in most situations.

Organizational Structure (refer to the end of this section for the organizational chart)

There is an organizational chart available that clearly illustrates the lines of authority. The chart is under revision because of the reorganization of the County methadone programs. Eden's program maintains job descriptions for all personnel, but these are, likewise, subject to change. Administrative records and reports are adequately maintained and used to guide the operation of the program.

A clear channel to ensure the accountability of the program's medical staff and other personnel to personnel outside of the program, or to the clients served by the program, needs to be established. Program personnel were unable to tell the evaluator to whom they were responsible in the County hierarchy. The program has had difficulty in obtaining community support and in linking up with other health and welfare services due to the lack of an aggressive outreach effort and absence of adequate management within the program.

Management

The recent reorganization of the County-operated methadone maintenance programs resulted in the placement of one person as program director for both County methadone programs. The new director had just assumed his position, and he was still familiarizing himself with the personnel and the operation of the program. The appointment of the new director* represents the third administrative change since July, 1975. This instability within the position of director has had several affects in the program. These are:

1. The staff are uncertain as to whom they are accountable since the previous director is still in the program but in another position (as of this writing, he, too, has left).
2. Internal communication processes are impaired because the new director is only part-time and unable to offer the necessary leadership that a full-time person could.
3. Decision making in the absence of a director is inadequate, as appropriate delegations of authority have not been finalized.

* As of January, 1976, the new director is no longer with either County methadone program.

Management (continued)

The new director has experience in the area of drug abuse but does not have proven administrative or management experience. The lack of sufficient administrative experience may prove a liability in the effective management of both County-operated methadone programs.

Personnel

There are a total of 11 full-time and four part-time personnel. One vacant Counselor position was also listed. The personnel are as follows:

*Richard D. Baldwin	Program Director (part time)
*George Wahl	Medical Director (part time)
George Papas	Physician (part-time)
Fred Medrano	Psychiatric Social Worker
Robert Huguenor	Psychiatric Social Worker
*Joanna Jurich/Betty Melendres	Secretary
Ann Castro	Specialist Clerk
Norma Daugherty	Health Representative II
Keith Olson	Health Representative II
William Koch	Addiction Counselor
George Marshall	Addiction Counselor
Erika Madrid	Public Health Nurse
*Judy Armstrong	Public Health Nurse
Gladys Monroe	Registered Nurse (part time)
*Sophie Miles	Addiction Counselor
Vacant	Addiction Counselor

*As of this writing, these persons are no longer with the program.

The program has more than a sufficient number of personnel to meet the needs of clients. According to the State's recommendations for counselor coverage, Eden should have a minimum of five counselors. In November, 1975, the program had seven counselors with one more position to be filled, totaling eight counselors in all.

Based on information furnished by the program, the following computations were made:

Staff - Client ratio	=	1 to 11.6
Counseling personnel - client ratio	=	1 staff to 20.7 clients

Counseling Productivity:

For a detailed description of how counseling productivity is arrived at, refer to the chapter in which all four methadone programs are compared.

Counseling Productivity: (continued)

Eden's counselors perform the following activities: intake screening, urine surveillance, counseling, recordkeeping, attend staff meetings and case conferences, answer correspondence, make referrals and conduct follow-up, plan treatment, and engage in collaboration with other staff members and community agencies. For the quarterly period ending September 30, 1975, Eden's counselors spent 46 percent of their available time delivering counseling services. An in-depth analysis of manpower utilization within Eden's program would be required in order to make judgments about the adequacy of time spent providing counseling.

Staff Training

The program has no organized staff development program. There is no formal orientation for new staff, no on-going training and/or continuing educational programs for all classifications of personnel.

Staff Problems

Staff morale was low, with the staff unable to cope adequately with changes in directors or the proposed reorganization. Since the site visits in November, 1975, four people have resigned. The reorganization has created some concern among certain staff members about salary levels and job classifications. Additionally, the program does not have in effect available staff grievance mechanisms.

The personnel problems and lack of adequate program leadership raise some doubt as to whether Eden can ensure that the program will be operated and managed adequately to provide the services required.

Financial Management

There is an operating budget which seems to have been developed based upon sound planning and accounting principles. However, the program does not have a reliable, accounting system. The budget accounts are maintained by another department of the County, and the program is not knowledgeable of current operating costs or other fiscal expenditures. The most recent record of program expenditures that the program had available was dated July, 1975. Also, there was a \$20,000 difference between program staff and the Office of Alcohol and Drug Abuse regarding the program's current budget.

Policies and Procedures (refer to the end of this section for a list of the program's Policies and Procedures)

Eden had written policies and procedures to implement the objectives of the program. However, some of the policies acted as a deterrent to clients utilizing services or interacting with program staff. For example, clients were instructed by staff to leave the program after dispensing hours.

The program did have specific dispensing hours which permitted adequate time for clients to receive methadone. In unusual situations, clients could receive medication outside of the normal hours.

Policies and Procedures (continued)

Hours of Dispensing

Monday - Friday	6:30 a.m. - 9:45 a.m.
	2:00 p.m. - 3:00 p.m.
	4:30 p.m. - 5:00 p.m.
Saturdays, Sundays, and Holidays	7:30 a.m. - 9:30 a.m.

Eden Laboratory Expenditures

As part of the initial physical examination of Eden, clinical laboratory tests are performed at Fairmont Hospital. The tests performed are listed below:

Urinalysis	\$ 3.60
Blood	
Cholride	6.00
CO ₂	6.00
Potassium	7.20
Sodium	7.20
BUN	6.60
Glucose FBS	6.00
VDRL	3.60
CBC	3.60
Protein total	12.00
Bilirubin	7.20
SGOT	7.20
AIK Phosphatase	<u>7.20</u>
TOTAL	\$83.40 per client

A review of laboratory costs at West Oakland and Herrick indicates that similar tests are performed at a far lower cost. West Oakland's cost is \$12 and Herrick's is \$8 to \$10 per client.

A comparison of the tests performed for the three programs are listed on the following page.

Eden Laboratory Expenditures* (cont'd)

<u>EDEN</u>	<u>WEST OAKLAND</u>	<u>HERRICK</u>
Urinalysis	Urinalysis	Urinalysis
CBC	CBC	CBC
SCOT	SGOT	SGOT
AIK Phosphatase	AIK Phosphatase	AIK Phosphatase
Bilirubin, total	Bilirubin, total	Bilirubin, total
Glucose	Glucose	Glucose
Chloride		
CO ₂		
Potassium		
Sodium		
BUN	BUN	
Total Protein	Total Protein	Total Protein
	Calcium	Calcium
	Cholesterol	Cholesterol
	Uric Acid	Uric Acid
	LDH	LDH
	Gobulin	
	Phosphorus	
VDRL	VDRL	
		Creatine
		INOR

* It should be noted that East Oakland does not perform any clinical laboratory tests, except for intake screening urinalysis.

In view of the comparative analysis, Eden should seek to negotiate with Fairmont Hospital in order to obtain less costly laboratory services. Should this not be successful, negotiation with a private laboratory should be undertaken. The savings which will result could be utilized to provide other expanded services to the clients.

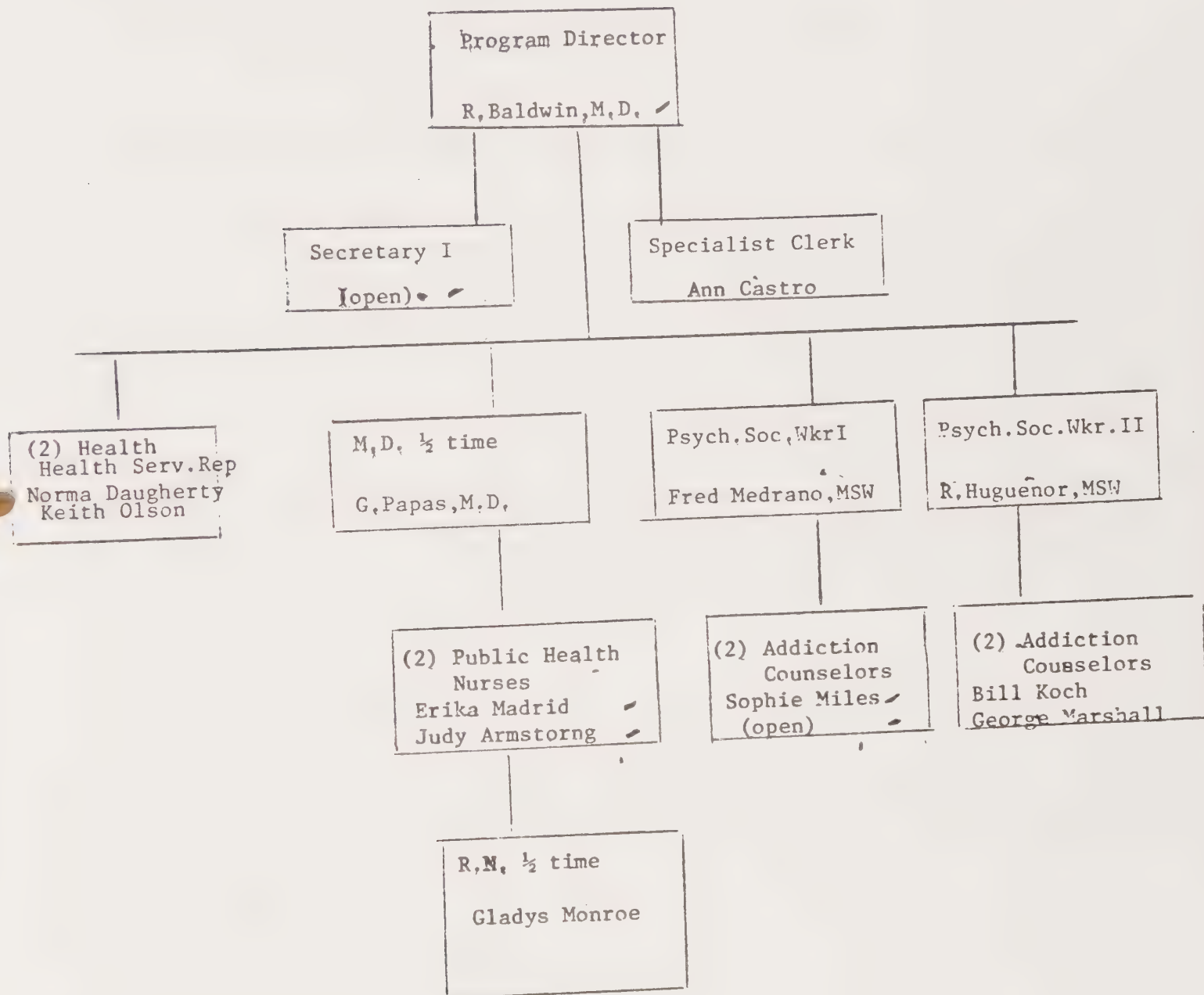
Conclusions

The main problem that Eden's program has suffered from is the absence of a program director with managerial capability. The staff, despite morale problems, seems motivated and concerned. Despite its management and clinical problems, Eden has highly favorable program results during the quarter ending September 30, 1975, as reflected by the following fact, that 70 clients remained totally free of opiates for the entire quarter.

Recommendations

1. Relocate the program to a more adequate facility.
2. Select a program director with proven administrative management experience and/or training.
3. Defer recruitment of the vacant Addiction Counselor until need can be assessed.
4. Develop an in-service training program for all classifications of employees.
5. Obtain more timely (within 30 days) expenditure reports to permit monitoring the program's fiscal affairs.
6. Develop a forum to guarantee client participation in the affairs of the program.
7. Negotiate for less expensive clinical laboratory service costs.

The agency is presently undergoing re-organization which will affect internal programs. Once this is finalized or revised, the new plan will be submitted.



GUIDELINES FOR EDEN DRUG ABUSE PROGRAM

PURPOSES OF THE PROGRAM

By providing narcotics addicts with methadone and with comprehensive rehabilitation and counselling services, the methadone treatment program:

- 1) Frees clients from dependence on the heroin black market
- 2) Discourages illicit drug use
- 3) Fosters stability in clients' lives (e.g. in regard to job, family, physical health).
- 4) Tries to increase the likelihood of eventual freedom from any drug dependence.

The program is staffed not merely to dispense methadone but to help clients build a stable life. It is more rehabilitative than therapeutic in orientation, less concerned with curing an illness than with helping people learn alternative ways of doing things. Staff help clients to get a job, to register for technical training and education, to take care of medical needs and to arrange legal counsel. Staff also provide marriage counselling or individual psychotherapy and generally try to ease a client's transition from being a junkie to getting straight.

If Methadone Maintenance Programs are to justify their existence, they must be able to demonstrate that they are achieving their purpose. This clinic will give preferred status to those clients who are demonstrating that they are benefiting from the program. As the supply of allocated methadone is smaller than demand, "carrying" a client who is not responding to the program is doing a disservice to potential beneficiaries on the waiting list.

CONFIDENTIALITY

All information regarding individuals who have been interviewed, examined, diagnosed, treated or rehabilitated in connection with this program should be held confidential and should be disclosed only when authorized by the individual in writing and then limited to the necessary information. Exceptions may be allowed in emergencies when disclosure is judged to be in the best interest of the individual. All disclosures shall be documented in the clinical record and reported to the affected individual.

ADMISSION CRITERIA

Requirements for admission include:

- 1) Voluntary participation
- 2) Informed consent
- 3) Age 18 or over
- 4) Residency in Southern Alameda County
- 5) Documented history of opiate addiction for two (2) or more years.
- 6) Documented history of detoxification failures on two (2) or more occasions
- 7) Physiological evidence of opiate addiction. Exception: No evidence of current addiction will be required of an individual applying for treatment within one week of discharge from a stay of one month or longer in a penal or extended care institution, if the State Department of Substance Abuse approves the admission.

- 4 -
- 8) Admission shall be denied an applicant when there is evidence of current multiple addiction (e.g. barbiturates or alcohol in addition to opiates). Exceptions may be made if a joint treatment plan can be negotiated with another appropriate treatment facility.
 - 9) Admission shall be denied an applicant when, in the judgment of the screening committee, the medical director or the program director, the personal history, physical examination, psychiatric evaluation or other information indicates that the individual would not benefit from treatment in this program.

INTAKE

Intake procedures will be designed to determine whether an applicant satisfies the admission criteria. These procedures shall include:

- 1) Personal history, including history of addiction, offense record, and employment history
- 2) Medical history and physical examination

Anyone who wants to be admitted to the program must first make an appointment with an intake worker. During the intake interview the candidate is asked questions about his personal history, etc., signs releases of information so that verifications of his history can be sent for, and provides the clinic with a urine specimen as partial evidence of current addiction. After evidence verifying the candidate's addiction history is received the client is given an appointment to be interviewed by the screening committee. Final determination of candidate's suitability for the program is postponed until after a scheduled medical examination.

ORIENTATION GROUPS

All accepted applicants are required to attend four (4) weekly group orientation sessions. These sessions are designed to inform clients about the effects of methadone, about the various services offered by the clinic, and about the demands of the program.

METHADONE DOSAGES

This program generally allows clients to know their dose. Induction schedules will be adjusted by the clinic physician on an individual basis. Any unobserved, spilled, stolen, lost or vomited doses will not be replaced.

THE STEP PROGRAM

The State of California's Department of Substance Abuse has devised a behavior modification program, a system of rewards and punishments, that by regulation must be used in all methadone maintenance clinics. The rewards are simple and few: Clients are allowed to be on the program if they meet the minimal requirements, and they are allowed to take home doses of methadone and thereby avoid the inconvenience of daily visits to the clinic if they satisfactorily adhere to the program rules over time. The longer the satisfactory participation in the program the more take-home doses are allowed. There are four (4) steps to be traversed in addition to the base level over a minimum period of two years. (See Table I) Punishments are also uncomplicated and consist of revocation or restriction of take-home privileges and suspension or expulsion from the program.

REVOCATION OF PRIVILEGES

The State requires that take-home privileges be revoked entirely when 1) Urinalysis discloses absence of methadone (the implication is that the client is circulating his methadone among friends or customers rather than using it himself). 2) The client is discovered to be misusing methadone (for example; sharing or selling). 3) The client is caught trying to beat a urinalysis. The State requires that take-home privileges be restricted if a client's urine is "dirty" two times or more in a sixty (60) day period or three times or more in a ninety (90) day period. Restriction means being moved back at least one step on the step program. A client will be considered "dirty" if a) the lab reports that his urine contained heroin, amphetamines, barbiturates, or other drugs b) he did not give a urine on a day he is scheduled to do so c) he is absent from the clinic without authority (AWOL) on a day he is scheduled for urinalysis d) he is observed in the clinic to be intoxicated on any substance.

RESTORATION OF PRIVILEGES

Privileges are restored for the same reason they were originally bestowed--satisfactory adherence to the program and its regulations--but the schedule for regaining privileges is shorter. (See Table II)

PROBATION

Probation is a step somewhere between regular membership and not being on the program. All new clients are on probation, as are all old clients without take-home privileges who continue to use illicit drugs. Clients on probation may be required to adhere to special rules and conditions to justify their continued participation on the program. New clients will be required to attend orientation sessions, see their counselors frequently, and eliminate their use of heroin and other illicit drugs. Old clients who have been put on probation will be required to adhere to conditions stipulated by their counselors. If the conditions of probation are not met successfully, the client will be suspended or expelled.

SUSPENSION AND EXPULSION

Acts that lead to the restriction or revocation of take-home privileges can, through persistence, become reasons for suspension or expulsion. A client is suspended if he is failing the program, but in the opinion of the staff, may benefit from a return to the program after thirty (30) days. A client is expelled if in the opinion of the staff he cannot benefit sufficiently from the program. Additionally, a patient is subject to immediate expulsion if his actions endanger the program. Examples are dealing in drugs in the clinic or its vicinity, selling methadone, carrying weapons on the premises and violence or threats of violence toward staff members and other patients. Such behavior brings a treatment program into disrepute, encourages police intervention and may lead to demands that the program be terminated. It is therefore a threat to all patients as well as to the program.

URINE TESTING

Urine specimens for screening shall be collected under the direct observation of staff. Clients shall be required to produce one or two random samples per week. More frequent specimens may be required at the discretion of the clinical staff. Urinalysis is the means by which a client demonstrates that he is abstaining from or continuing to indulge in the use of illicit drugs.

VOLUNTARY DETOXIFICATION (TAPERING)

A client may taper voluntarily from methadone at any time during treatment. Prior to any actual reduction in dose, a meeting of the client's counselor, the counselor's supervisor and program physician shall be held to discuss the individual's performance on the program and to support or discourage his tapering plan. If it is the consensus that tapering would be unwise, the counselor will explain the staff's reservation to the client and propose an alternative plan. If the client wishes to taper despite the counselor's recommendation, he will be permitted to do so, but not on his own terms. Most likely the client will be offered a 30-day detoxification. Clients cannot be permitted to volunteer for long slow detoxifications unless their participation in the program is otherwise satisfactory.

INVOLUNTARY DETOXIFICATION

A client responsible for an act of violence or threat of violence against a staff member or another client on the program shall be terminated from the program after being tapered off methadone within a period of fifteen (15) days.

Suspension and expulsion for unsatisfactory participation on the program (e.g. for continued use of heroin) is usually implemented with a 30-day detoxification schedule.

TABLE I

TABLE II

GAINING TAKE-HOME PRIVILEGES WHEN
INITIATING PROGRAMREGAINING REVOKED TAKE-HOME
PRIVILEGES

First 3 months on program NO TAKE-HOME Come to Clinic 7 days/week	First month (30 days) after revocation NO TAKE-HOME Come to Clinic 7 days/week
STEP I After 3 months of satisfactory participation on the program Sunday take-home Come to Clinic 6 days/week	STEP I After 1 month of satisfactory participa- tion in program Sunday take-home Come to Clinic 6 days/week
STEP II After 6 months of satisfactory participation on the program Saturday and Sunday Take-home Come to Clinic 5 days per week	STEP II After 3 months Saturday and Sunday take-home Come to Clinic 5 days/week
STEP III After one year of satisfactory participation in the program Two 2-day take-home/week Come to Clinic 3 days per week (Monday, Thursday, Friday)	STEP III After 6 months Two 2-day take-home/week Come to Clinic 3 days per week (Monday, Thursday, Friday)
STEP IV After two years of satisfactory participation in the program One 3-day take-home, plus one 2-day take-home/week Come to Clinic 2 days/week (Monday and Thursday)	STEP IV After 9 months One 3-day take-home/week, plus one 2-day take-home/week Come to Clinic 2 days/week (Monday and Thursday)

PROBATIONARY
PERIODREGULAR
MEMBERSHIP

EAST OAKLAND METHADONE PROGRAM (COUNTY)

Facility

The program is located at 6400 Foothill Boulevard, Oakland, on the lower level of a two story apartment complex. The facility is not well maintained and has a poor layout. The furniture near the front entrance is dilapidated and in need of replacement. The fear of possible theft of new furniture was one reason given for maintaining such unsightly furnishings. The layout precludes adequate client flow for the following reasons: 1. a bottleneck is created at the dispensing area; 2. there is difficult access to some counselors' offices 3. toilet facilities are inadequate for proper urine surveillance.

Slots Approved, Funded, and Filled

Number of treatment slots approved	75
Number of treatment slots budgeted	75
Number of treatment slots currently filled	76
Number of clients on waiting list	57

*Source: Methadone Maintenance Program Quarterly Report to the State for period ending September 30, 1975

The current occupancy level of 76 clients results in a yearly average cost per client of \$2,250. This figure is arrived at by dividing the program's budget of \$171,036 by the number of clients enrolled.

Age, Ethnicity, and Sex of Client Population

<u>Age</u>	White		Black		Mex-Amer.		Other		Total		Total
	M	F	M	F	M	F	M	F	M	F	
Under 21	0	0	0	0	0	0	0	0	0	0	0
21-25	5	2	6	2	0	0	0	0	11	4	15
26-35	11	4	10	3	6	2	1	1	28	10	38
36-45	4	1	5	3	5	0	0	0	14	4	18
46-65	1	0	4	0	0	0	0	0	5	0	5
Over 66	0	0	0	0	0	0	0	0	0	0	0
TOTAL	21	7	25	8	11	2	1	1	58	18	76

Source: Methadone Maintenance Program Quarterly Report for period ending September 30, 1975. Report is prepared by the program for submission to the State of California, Department of Health.

Program Objectives

The objectives of the program, as well as the services which are offered, are clearly stated and are designed to implement the concept of a client-oriented service delivery system. Specifically, services will be offered to clients through individualized treatment planning and on the basis of the clients interest in, or willingness to receive, the services that are offered.

The concept of client-oriented service was developed to foster voluntary participation by motivated persons and to minimize the number of mandatory program requirements. The idea is admirable, however, the application of the concept has raised a number of issues. First, the high number of clients (95 percent) having illicit drugs in their urine in the last quarter may indicate a low motivation to participate in the new approach; second, the basic eligibility criteria and client characteristics may not relate to the requirements of a client determination of treatment content and third, adequate staff identification and support of the new system needs to be generated to provide adequate treatment and logistic support.

Organizational Structure (refer to the organizational chart at the end of this section)

The recent reorganization needs to be supplemented by clearly defining the channels of responsibility and authority. Attention should be given to the alignment of job functions to eliminate overlap between the Chief Psychiatric Social Worker's responsibilities and those of the Chief Counselor, i.e., the responsibilities for staff training, leading case conferences. Relationships to counseling staff are not clearly defined at this time in written job descriptions.

Administrative records and reports are adequately maintained, however, they have not been integrated with overall program functions, such as with clinical, nursing and medical activities. For example, nurses' perceptions of client behavior are not incorporated in the clinical records, and nurses do not participate in case conferences. In one case conference attended by the evaluator, the clinical records were not utilized as part of the discussion process.

Management

As part of the reorganization of county-operated methadone maintenance programs, the medical director of East Oakland was appointed to the position of Program Director of Eden and East Oakland. The change has had the affect of relegating the Chief Psychiatric Social Worker, who formerly was the director, to a position of program administrator. As mentioned in the management narrative of Eden, the new overall director possesses no management experience. Additionally, the program lacks an overall management system in which to monitor its performance. The activities of the staff and clients are not adequately coordinated and the staff functions largely on an individual basis, rather than as a team.

Personnel

As of November, 1975, there were a total of six full-time and three part-time personnel. Also, one vacant, addiction counselor position was listed.

Richard Baldwin, M.D.*	Program Director (PT)
Timothy Ray	Chief Psychiatric Social Worker
Faith Porter	Psychiatric Social Worker - Chief Counselor
Ted Nishio	Psychiatric Social Worker
Tom Thompson	Addiction Counselor
Hal Toops	Lead Clerk
Carmen Belloso	Clerk
Dorothy Goodman	Registered Nurse (PT)
Betty Rowe	Registered Nurse (PT)
Vacant	Addiction Counselor

* As of this writing, Dr. Baldwin is no longer with the program.

The program has a sufficient number of personnel to meet the needs of clients. According to the State's recommendations for counseling coverage, East Oakland should have a minimum of 2.5 counselors, and the program has 3 counselors.

Staff - Client ratios:

Based on information furnished by the program the following ratios were computed:

Staff - client ratio	1 to 10.1
Counseling personnel - client ratio	1 to 25.3

Counseling Productivity

For a detailed description of counseling productivity, refer to the chapter in which all four methadone program are compared.

East Oakland's counselors perform intake screening, urine surveillance, counseling, record-keeping, attend staff meetings and case conferences, answer correspondence, make referrals and conduct follow-up, plan treatment, and cooperate with other staff members and community agencies. For the quarterly period ending September 30, 1975, East Oakland's counselors spent 42 percent of their available time in counseling services.

Staff Training

Formal in-service training needs to be provided for all staff. Specialized programs such as the AA degree in drug abuse counseling and the judicious use of educational programs and consultants need to be expanded.

Staff Problems

There have been no changes in the counseling personnel for one year. However, there has been turnover in clerical and nursing positions. Nursing turnover has resulted in inadequate coordination of medical care. Part-time nurses perform dispensing activities and are not integrated into the other clinical activities.

There currently is a vacant addiction counselor position. Recruitment should be delayed or even curtailed until proper utilization and performance criteria for existing positions are determined. This is essential, especially if counseling is made voluntary. In a voluntary system, one should anticipate a decrease in the frequency and duration of counseling contracts and a reduced need for counseling personnel.

Male and female personnel should be available to ensure adequate urine surveillance. During the site visit, complete coverage for urine testing was not always available.

Financial Management

Reports of expenditures are furnished to the programs 120 days or more after the expenditures are made. Thus, it is difficult to know the program's current financial position.

Production and communication of expenditure reports need to be accelerated so that methadone program managers can exercise decision based on current knowledge of expenses.

Policies and Procedures (refer to the end of this section for a listing of the program's policies and procedures)

East Oakland has written policies and procedures to implement the objectives of the program. However, administration has been inconsistent.

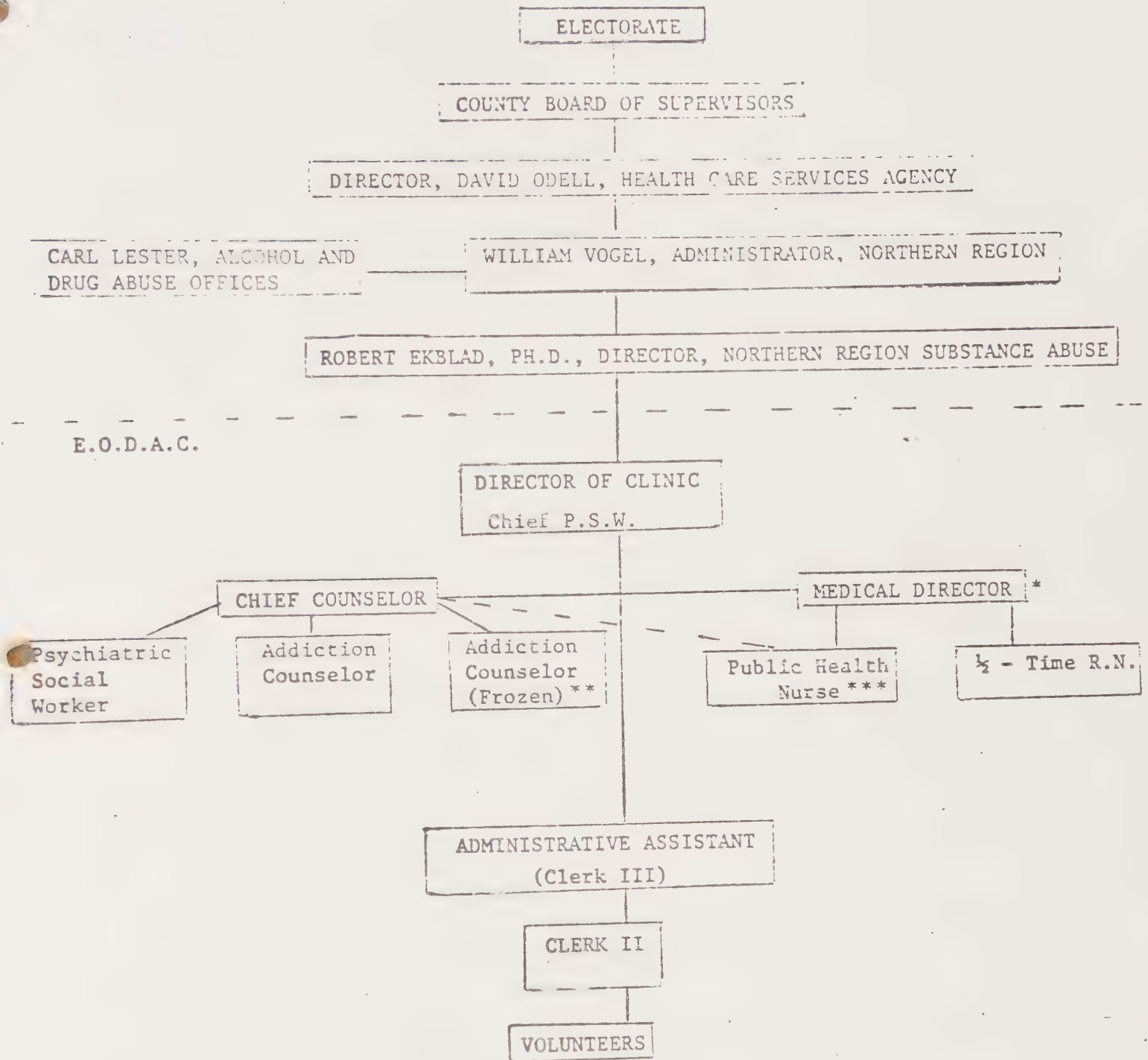
Conclusions

East Oakland lacks a coordinated administrative structure, and efforts should be undertaken toward internal team building. New policies and procedures should become part of an internal evaluation process, so that the affect they may have on program operations can be determined.

Recommendations

1. Select a capable contractor to perform maintenance and housekeeping services.
2. Re-arrange physical layout to better accommodate staff and client needs.
3. Provide clean and comfortable furnishings to clients.
4. Conduct client and staff orientation program for "Client-Oriented Service Delivery System".
5. Review client screening process to insure selection of motivated clients, if the client-oriented system is, in fact, to be implemented.
6. Revise job descriptions to insure that listed functions are aligned for all staff members.
7. Select a methadone program director with proven ability in management.
8. Defer recruitment and hiring of an additional addiction counselor until the need for the counselor is established.
9. Develop an in-service training program for all classifications of employees.
10. Review functions of nursing personnel to insure their inclusion in the development and monitoring of client treatment.
11. Develop measurable criteria by which staff performance can be evaluated.
12. Obtain more timely (within 30 days) expenditure reports to permit more adequate monitoring of fiscal affairs.
13. Enforce program policies in a consistent manner.
14. Review the current policy of using methadone discettes. Using methadone in liquid form may be more efficient.
15. Evaluate the affects of the new policies regarding urinalysis results.

ORGANIZATIONAL CHART - Prior to the Reorganization



POLICIES AND PROCEDURES - EAST OAKLAND

Beginning November 1, 1976, a new policy will be in effect at the East Oakland Drug Abuse Program. To sum it up, the policy is that, to stay on this program, a person must be clean most of the time (not using non-prescribed drugs). Anyone who follows this will not have to worry about the details of the policy.

In detail, the new policy will work like this: Any member who has 50 percent or more dirty urine tests, over a 90-day period, receives a 30-day detoxification, to be followed by 30 days time off the program. After that, a staff decision will determine whether he is re-admitted to the program on a 90-day probationary period. If the same person has 50 percent or more dirty urine tests during the 90 days following readmission on probationary status, he will receive another 30-day detoxification, and his name will be added to the bottom of the waiting list (or else, he will not be reconsidered for readmission to the program for at least 90 days, whichever is longer). But, if he is clean during the 90 days after readmission on probationary status, he then gets off probationary status and is like anyone else.

There are several more details to this policy:

1. If a person gives so many dirty tests during the first part of a 90-day period that he has already given 50 percent dirty tests for that period, his detoxification starts then, instead of waiting till the 90-day period is over.
2. A 90-day period can start at any time. The months November, December, and January, altogether, would be one 90-day period; December, January, and February would be another (approximate, in both cases). In other words, they may overlap. This means, do not assume you can be clean for several weeks and then dirty for the last half of a period, because you may be giving 50 percent dirties or more, during another 90-day period.
3. Violence or threats of violence, in or around the clinic, will still result in a 14-day detoxification - not a 30-day detoxification.
4. Staff will have the discretion to check all members' urine records at one time, for the purpose of enforcing the new policy, or to check only a part of all records at one time. If staff checks only a part of all records at one time, those checked will be selected at random to ensure fairness.
5. There will be no more "contracts" for the purpose of pressuring a member to give a certain number of clean tests. It is now up to the individual: the individual

either meets the standard in terms of giving clean tests or he does not meet it.

6. Any time a person is readmitted to the program, he starts earning take-homes if he is clean (along with the other requirements for take-homes, which are that the person is meeting the requirements of the program and also that he is either employed, in training, or at home looking after young children). There is no change in this policy. See your counselor if there are any questions about take-homes or other policies.
7. When a new member is admitted to the program for the first time, his first 30 days on the program will not be counted as part of a 90-day period.
8. If a person who gets detoxed as a result of dirty urine tests returns to the program 60 days or more after his last detoxification, his first two weeks back on the program will not be counted as part of a 90-day period.
9. All persons on prescribed medications are expected to give the Clinic permission to talk with the doctor who gave the prescription. This permission is by means of a form we have. Please do this as soon as you get the prescription, so we will know about this before the urine test is given where the medication shows up. Also, bring the bottle the pills came in and show it to your counselor. This is not a new policy, but it is being repeated for general knowledge.
10. The staff has the right to make exceptions to the new policy, but this would be only under very rare circumstances where there is justification.

The reason for the new policy is that we have only a limited number of treatment slots and a long list of persons waiting for an opportunity to be admitted; so, it is necessary for a person to decide whether being on the methadone program or being on other drugs is more important for him or her. Anyone who has any questions about new policy should see his or her counselor as soon as possible. Staff is available for discussing personal problems, vocational matters, etc.

THE CLIENT ORIENTED SERVICE DELIVERY SYSTEM

Within the Methadone Maintenance Treatment Program

A. THE CONCEPT

The concept of a client-oriented service delivery system within a Methadone Maintenance Treatment Program, means that services will be offered to clients (1) through individualized treatment planning and (2) on the basis of the client's interest in , or willingness to receive, the services that are offered.

Several fundamental propositions are essential to this concept of a client oriented system. (1) For effective treatment, it is appropriate to minimize the number of mandatory elements in the overall treatment program, consistent with control and monitoring of methadone, in order (a) to foster voluntary participation in treatment services by motivated persons and (b) to eliminate power struggles which focus around the mandatory element in treatment and which are often triggered by that element.

(2) A variety of services should be offered to meet different types of needs clients have, based on :

- (a) Interests and needs of clients,
- (b) Skills of personnel and resources of the Clinic
- (c) Resources available in the community for collaborative efforts, conjoint case planning, or referral of clientele for additional services as appropriate.

(3) Effective treatment depends upon affording the client the dignity that is due to an adult citizen and this dignity involves (a) maximizing client choice and self-determination, and (b) informing clients fully and honestly as to program expectations, requirements, and options. Fundamental to this concept is the obligation to make clientele aware of the tools which the clinic offers toward the resolution of his/her drug addiction, with its underlying causes, and to inform the client initially of the time limits within which methadone maintenance treatment services are to be made available.

B. ELEMENTS OF THE CLIENT-ORIENTED SYSTEM

The client-oriented service delivery system includes minimally the following components:

(1) Mandatory Elements - These include daily ingestion of prescribed medication at the clinic or by means of duly earned take home doses, and provision of urine specimens as required. Some degree of contact between the individual client and the staff person assigned to be his/her counselor is also essential. This implies that, in order to participate in the methadone maintenance treatment program, the client must be willing to comply with expectations that he/she confer with the assigned counselor, and that this be done on any occasion on which it is reasonably requested.

The counselor is the client's primary point of contact with the methadone maintenance treatment program and is involved in all matters pertaining to the client's membership in the program and participation in both involuntary and voluntary elements. The counselor-member relationship is the heart of the program and the fundamental element for the fostering of client growth and rehabilitation.

Attendance at a mandatory Orientation Group may also be required of the new client. Ordinarily, this will be limited to a period of about three months time.



The purpose of this group is to provide ongoing education to the new client as to the clinic's program and policies, and to answer clients' questions and to provide needed information. Also, this group participation provides the new client with an opportunity to experience himself in a group situation and to begin to examine himself in light of the feedback which he receives from the group leaders and from fellow members.

(2) Voluntary Elements - To regard and treat the client as an adult citizen implies respecting his ability to understand the services which are available, when these are explained to him in a thorough manner. It also implies telling him what is recommended for him by the staff as a result of the staff's evaluation of his situation and needs, and allowing him to make his/her own decision as to whether or not to accept these recommendations.

To maximize client self-determination implies being clear about the outer boundaries of available choice: in this case, informing the client initially of the time period during which treatment is to be offered to him. A periodic reminder, such as every three months, would also be helpful, since initial explanations are not always clearly understood where a person has been recently using drugs.

Voluntary elements can include such services as the following: family and couples counselling, recreation group activity, intensive group and individual therapy (to include special techniques such as psychodrama, Gestalt, T.A., etc., as appropriate), health education group, a women's group (to focus on special problems and needs of women), a vocational-educational service component, community-exposure activities (e.g., trips to see educational or recreational events and resources), and others as needed, desired, and practicable.

An important aspect of service-delivery pertains to linking up the client who has a need with the agency providing a service. This can include such agencies as Public Health, Legal Services, Training, Employment, and Budgeting and Tax Accounting.

C. DYNAMICS OF THE CLIENT-ORIENTED SYSTEM

The client-oriented system can best be understood in terms of a process of flow through the system. Client flow can be conceptualized as consisting of five steps, which are, in chronological order, the Intake Process, the Linkage Process, the Continuing Treatment Phase, the Preparation Phase, and Discharge.

(1) The Intake Process. This includes the entry of the client into the system. He may walk in, in response to his own interest in the methadone maintenance treatment program, or he may be referred by other persons or agencies in the community and thereafter come in to make application in person. In either case, he is interviewed in order to gain a thorough understanding of both his addictive pattern and history and his underlying medical, psychological, social, economic, legal, educational, ~~social~~ and environmental problems. This understanding enables the Medical Director and the other members of the treatment staff to determine whether the applicant meets the entrance requirements and, if he is admitted, provides the basis for the subsequent individualized treatment program.

(2) The Linkage Process. If the applicant is accepted into the program, a counselor is assigned to work with him and to be his social broker in dealing with the various resources of the system. The counsellor may assist the client, at this point, by scheduling him for an additional appointment with a social

worker on the staff, in order to provide information, referred, and other assistance to the client in dealing with the various social welfare agencies within the County which can provide immediately needed financial aid, child welfare assistance, or other social services of an emergent nature. Also, the counsellor can schedule an additional appointment with a physician on the clinic staff in order that the physician can discuss with the client his and his family's medical history and health needs and to assist the client in utilizing the regular health resources of the community, including private practitioners' services, public clinic services, etc. This should be an important and ongoing part of the total treatment and rehabilitation process. The counsellor maintains contact with the social worker and physician to facilitate the process and assist the client with subsequent follow through.

In addition to scheduling appointments, the counsellor now works actively with the client to attempt to secure the client's linking up with the various services offered within and outside of the clinic which the counselor and staff feel that the client needs. In doing this, he explains to the client how he, the counselor, perceives the client, his resources or strengths, and his present needs. Accordingly, he also recommends to the client the specific services (vocational, educational, psycho-therapeutic, recreational, health, etc.) which constitute the counselor's, and the staff's prescription to the client to facilitate his successful rehabilitation, or at least to maximize the probability of his attaining this goal.

A rehabilitated client would be one who has achieved a life which is satisfying to him, substantially free of conflict with society's norms and control mechanisms (police, courts, etc.) and, optimally, socially and economically productive (or at least not destructive). To attain such a life, the individual will have to gain mastery over his own conduct and freedom from domination by drugs and drug purveyors. The goal of freedom from narcotics can often be more effectively pursued by focusing on the individual's total growth and fulfillment than by a near-sighted preoccupation with the drug usage itself. It is usually necessary for the counselor to work with the individual on the drug problems, but this should not absorb a disproportionate amount of counselor's and client's attention. Goal setting arrived at through casework interviews can appropriately include the targeting of reduced drug usage, in the context of pursuing social and the rehabilitative goals.

As the counselor makes known to the client the counselor's and the staff's prescription for needed services, he concretely explains to the client each of the service components and how that service is made available, together with its appropriateness and relevance for the individual. This is to be construed as an ongoing process that may best be done over a period of time as the counselor and staff gain better acquaintance with the client and as the counselling relationship further develops.

Included in this phase is entry by the client into the various specialized groups or other service components, both within and outside of the clinic, as are recommended. Thus, the client may begin to participate in a mandatory orientation group on March 1, enter a vocational evaluation process on March 15, begin to participate in recreational and community outings by April 1, and join a couples counselling group (together with his mate) on June 1. During this process, the evaluation of needs and the formulation of objectives are ongoing.

It is to be understood that the client, as an adult citizen, retains the right to refuse to accept recommendations for participation in voluntary program components.

He may prefer to accept the methadone which is provided without availing himself of the other available services, despite the fact that the other services are recommended and prescribed by the staff. He has the obligation to comply with all Clinic regulations regarding methadone and urinalysis, to see his counselor whenever a reasonable request for an interview is made by the counselor, and to participate in an orientation group. Other than meeting these expectations the individual has the right to pursue his rehabilitation through his own efforts. The clinic staff do retain the right to confront persons who continue to use illegal drugs while on the program and, in extreme cases, to insist that the person leave the program for a period in order to evaluate his own motivation for change.

3. Continuing Treatment Phase. This is the longest part in time of the individual's participation in the program. He takes part in those program components in which he is enrolled. The individual is free to request changes in his treatment program during this time if he wishes to do so. However, if he requests admission to a program component, he should be urged to attend or participate regularly. If he/she decides to terminate a particular group or activity, shortly after beginning, he should realize that he may be expected by the activity or group leader, and the other participants, to explain the reasons for his entry and termination. He also may be questioned if he agrees to participate but then fails to attend, or attends sporadically. The reason for this is that rehabilitative programming is meant seriously and expressions of interest should be sincere.

This is not to preclude trial participations, on an exploratory basis, if this is indicated at the outset. The activity or group leader may need to evaluate whether a particular program component can appropriately lend itself to this type of participation. In so doing, he may consult the other participants, although he/she continues to be responsible for the particular activity which he is leading. Each program component must be periodically evaluated in terms of its role in the overall operation of the clinic, the contribution which it makes to meeting appropriate rehabilitative goals, and its availability for therapeutic programming for additional clients.

4. PREPARATION PHASE. Toward the end of the client's treatment program, his treatment program should begin to be oriented toward termination. This may be reflected as a narrowing of his program interests, a reduction of the number of program components in which he participates, and in his taking part in planning that is directed toward needs which he will face after termination of methadone maintenance. Primary among these needs is the continued availability of counselling services, either in the clinic or by referral elsewhere, after termination.

The individual may terminate the program of the clinic either by his own choice or by a staff decision. In either case, the clinic is responsible for offering pre-discharge planning, as we must remain available to assist the client in making plans to meet his needs, despite the termination of methadone maintenance treatment. A formal aftercare plan should be prepared and discussed with the client. The plan should become a part of the individual's clinical chart.

During the Preparation Process, the client's daily methadone dosage is decreasing by a medically established schedule, and he will often need additional counselling to help him understand the accompanying mental and physical changes which he may be experiencing.

5. DISCHARGE. When a client discharges from the program, the Aftercare Plan is implemented. Effective referral at this point means being responsive to the needs of the client for either a well-defined connection with another agency or for a more informal and contingent arrangement. In the latter case, the client should be clearly told how to contact the agency to which he is being referred and any requirements which must be met in receiving services from the other agency. This should be given to him in writing. On the other hand, a formal referral to another agency involves the counsellor contacting the receiving agency to insure client acceptance as well as clearly notifying the client verbally and in writing.

The client terminating methadone maintenance services should be offered the option of continuing to come to the clinic for counselling services where this may be preferable to referral elsewhere. In some cases, it will be appropriate to keep the case open and to report services received, as before, for billing purposes. When a formal arrangement of this nature has been made with the client, he may continue to attend group sessions or activities, according to a set schedule, as before. Creation of a Graduates Group may be necessary to assist active clients in making a decision to taper off methadone without fear of thereby losing their acceptance by, and right to participate in, the clinic itself. Later, such a group can assist the detoxified client in remaining drug free.

It should always be made clear to a terminating client that he has the right to return to the clinic for counselling without the necessity of first becoming readdicted to drugs. He may receive services in the future, even though he may be no longer a using addict, and, in fact, early contact should be made when anxiety is experienced, so that the clinic can provide counselling assistance to the client who is seeking to avoid a possible relapse.

The long range goal should be the autonomy, freedom, and self-determination of the individual. The achievement of this goal may have to be piecemeal and based on the individual's gradually growing strengths. The development of these strengths can best be fostered by a program which offers a client oriented service delivery system.

COMPARISON - METHADONE PROGRAM EFFICIENCY

This section draws valid comparisons among the two county and two contractual methadone programs. We go to some length in addressing all physical, environmental and program variables affecting the comparisons so that the reader can gain proper perspective. Particular attention will be given to the issue of county operated versus contractual programs. However, comparisons in this area are difficult because of the wide differences in clientele and social/cultural environment affecting each program.

Cost

Tables 1 and 2 on the following pages depict the yearly unit costs for the programs. In Table 1, the current unit cost is determined by dividing the total, annual program budget by the occupied number of treatment slots. For example, the unit cost per occupied slot at Eden is:

<u>Total Budget</u>	<u>\$274,446</u>	=	\$1,893 per occupied
Number of occupied slots	145		methadone slot at the
			current level of occupancy.

Obviously, a program that does not have an occupancy slot level equal to the funded slot level will cost more money until the two are equal. Thus, as Eden approaches its approved funding level of 150 slots, its unit cost will decrease. This fact is illustrated by Table 2, wherein unit cost is determined by dividing the program's annual budget by the number of approved slots.

One might argue that county methadone programs are more expensive. However, county personnel costs are always shown to be at the highest level in the pay scale, regardless of the true salary of the employees. This tends to make budgets somewhat higher. The other actual fixed and variable costs for county and contract programs should closely approximate each other in a competitive market.

In the analysis of the ratio of actual costs to the accepted standard of \$1,500 per year for unit patient methadone treatment (Table 3), one can see varying unit costs among the four programs. However, there are potential cost efficiencies in program operations which will result in the unit cost approximating a standard of \$1,500 and tend to equalize the four programs. For example, in Eden, the current unit cost per approved or funded methadone slot is \$1,830 per client per year. Review of Eden's program reveals the following factors as contributing to the excess over standard.

1. Budgeting of eight counselors for 150 clients when five counselors may be adequate.

TABLE 1

UNIT COST PER OCCUPIED METHADONE SLOT

	Herrick	West Oakland	Eden	East Oakland	Total
Total Budget	\$180,000	\$303,733	\$274,446	\$171,036	\$929,215
Occupied Slots	103	185	145	76	509
Average Cost Per Slot	\$1,748	\$1,642	\$1,893	\$2,250	\$1,883

* Rough estimates from the Special Action Office for Drug Abuse Prevention indicate the standard cost per client year to be approximately \$1,500 for outpatient methadone care. Source: "Quick Evaluation Methodology", Special Action Office for Drug Abuse Prevention, October, 1973.

Percent of Occupied Slots to Authorized/Funded Slots*

	<u>Herrick</u>	<u>West Oakland</u>	<u>Eden</u>	<u>East Oakland</u>
Percent of occupied slots to authorized slots	103%	93%	97%	101%

* Percent of Occupied Slots to Authorized/Funded Slots -

Computed by dividing occupied slots by the number of funded slots. Used to determine current operational efficiency of each program. It is possible for a program to have more clients enrolled than the number of treatment slots authorized because programs are allowed to have 10 percent more clients than the number for which they are authorized and funded.

TABLE 2

UNIT COST PER APPROVED METHADONE SLOT

	Herrick	West Oakland	Eden	East Oakland	Total
Total Budget	\$180,000	\$303,733	\$274,446	\$171,036	\$929,215
Approved Slots	100	200	150	75	525
Average Cost Per Slot	\$1,800	\$1,519	\$1,830	\$2,280	\$1,857

* Rough estimates from the Special Action Office for Drug Abuse Prevention indicate the standard cost per client year to be approximately \$1,500 for outpatient methadone care. Source: "Quick Evaluation Methadology", Special Action Office for Drug Abuse Prevention, October, 1973.

TABLE 3

RATIO OF ACTUAL TO STANDARD BUDGET*

	<u>Herrick</u>	<u>West Oakland</u>	<u>Eden</u>	<u>East Oakland</u>
Ratio of actual to standard budget	1.17	1.09	1.26	1.50

* Ratio of actual to standard budget -

Computed by dividing the unit cost per currently filled slot by \$1,500. \$1,500 represents the estimated cost for an outpatient methadone program per year. Ratios should approximate 1.0.



2. Cost of performing client urinalysis twice a week is more expensive (regulations require urinalysis once weekly). For 150 clients, yearly cost of taking one urine test per week at \$2.25 per test equals \$17,550. To take two tests per client per week costs twice as much, or \$35,100.
3. The contract with Fairmont Hospital for laboratory services is expensive (refer to the section on Eden for details).
4. Eden could probably generate some client revenues. The last statistical report to the State indicated that 56 percent of the clients were employed.

In the same fashion one factor contributing to East Oakland's higher unit cost is personnel. East Oakland was budgeted for an addiction counselor that may not be needed. Also, salaries of employees are listed at the top of the pay scale, regardless of the true salaries. More important in contributing to the higher unit cost is the program's number of approved treatment slots. Preliminary analysis reveals that a program cannot operate for 75 clients and pay for personnel and other services on \$1,500 per client per year. There are just too few clients to absorb the fixed costs. Economic viability begins to appear at the 100 client level. For East Oakland, an increase in client enrollment to 100, along with the proper utilization of existing personnel, would reduce its unit cost to levels comparable with the other three programs. Also, the program could probably generate some client revenues. The last statistical report to the State indicated that 33 percent of the clients were employed.

We are not recommending an increase in East Oakland's treatment slots at this time. Although an increase in slots would make the program more cost efficient, other treatment considerations must be taken into account. A detailed description of the evaluation team's recommendation to maintain only existing methadone treatment slots at this time can be found in the "Recommendations and Discussion" section of the methadone impact section. Consideration of cost efficiency should not take place in isolation of related impact issues.

In the West Oakland Program potential cost reduction factors include:

1. Administrative overhead assessed by the parent health center.
2. Budgeting of eight counselors and five nurses when seven counselors and four nurses may be adequate.

Herrick's program receives SB 714 funds in the amount of \$124,696 yearly. The program also receives a grant from the City of Berkeley in the amount of \$24,000 per year. The hospital comptroller has indicated that the true operating cost for the program, considering all indirect, overhead, and inflationary factors is \$180,000 per year. He also estimated that the program generates about \$1,200 per year in client revenues. The difference between revenue and operating expenses is \$30,104 per year. The hospital is currently bearing a loss for the program by partially underwriting indirect program costs, such as overhead, utilities, and janitorial services.

An analysis of cost efficiency across programs indicates that, with a minimum approved client level equal to, or exceeding, 100 clients, program costs probably can be maintained near the \$1,500 per client year cost for programs whether county or contract. This is especially true if the programs are filled to funded capacity. Efforts could be made to reduce costs at Eden and West Oakland. The issue of comparative cost should be examined again, after appropriate changes have been made to reduce current program costs. However, quality issues should not be lost sight of in any discussion of cost efficiency.

Staff - Client Ratios

Another important issue in comparing program efficiency is the ratio of staff to clients. Also, comparing counseling productivity can provide additional information on program efficiency. An examination of Table 4 shows that Herrick has the heaviest client load in relation to available staff. This is particularly striking in the staff - client ratio. Also, the contractual programs tend to absorb a higher counselor - client workload than their County operated counterparts. However, aside from Herrick's positive ratios, there are no substantial differences among the programs.

TABLE 4

Staff - Client Ratios

	<u>Herrick</u>	<u>West Oakland</u>	<u>Eden</u>	<u>East Oakland</u>
Staff - Client Ratio*	1 to 17.6	1 to 10.1	1 to 11.6	1 to 11.3
Counselor - Client Ratio**	1 to 29.4	1 to 25.3	1 to 20.7	1 to 23.1

Staff - Client Ratio*

Computed by dividing the full-time staff equivalents into the current client population. For methadone programs the staff - client ratio should approximate one staff member to 15 clients. Source: "Quick Evaluation Methodology", Special Action Office for Drug Abuse Prevention, October, 1973.

Counselor - Client Ratio**

Computed by dividing the full-time counseling staff equivalents into the current client population. For 1 counselor, there should be no more than 30 clients. Source: State Regulations for Methadone Programs, Welfare and Institutions Code California.

Counseling Productivity

This measure for each methadone program was determined in the following manner:

1. The total number of counseling units delivered by each program was taken from the program's statistical quarterly report to the State, September 30, 1975.
2. Several assumptions were made by the evaluator -
 - a) A productive work week equals 30 hours per counselor.
This allows time for lunch and coffee breaks.
 - b) A productive work quarter equals 390 hours per counselor.
 - c) All work is considered to be distributed evenly among the counselors.
 - d) Units of counseling were converted to time as follows:

Individual Counseling	1 hour
Family Counseling	1½ hours
Group Counseling	2 hours
Vocational Counseling	1 hour
Recreational Counseling	1½ hours

These time estimates are adequate even though the evaluator recognizes that some group counseling may extend beyond two hours, just as some recreational counseling may extend beyond one and a half hours. This is balanced by the fact that not all individual counseling takes one hour. Just the same, the reader should keep in mind that counseling productivity is merely an estimate, and not based on a time distribution survey.

Each program has the following full-time equivalent counseling personnel:

Herrick	3.5 persons
West Oakland	8.0 persons
Eden	7.0 Persons
East Oakland	3.0 persons

Multiplying the number of full-time personnel in each program by 390 working hours for the quarter ending September 30, 1975, the following available counseling hours were computed:

Herrick	1365 hours
West Oakland	3120 hours
Eden	2730 hours
East Oakland	1170 hours

From each program's quarterly statistical report, the following counseling units were recorded:

<u>Type of Counseling Service</u>	<u>Herrick</u>	<u>West Oakland</u>	<u>Eden</u>	<u>East Oakland</u>
Individual	446	441	1127	436
Family	0	14	67	0
Group	51	110	0	30
Vocational	0	17	30	0
<u>Recreational</u>	<u>2</u>	<u>8</u>	<u>0</u>	<u>0</u>
TOTAL UNITS	499	590	1224	466

When the units of service are converted to time spent providing counseling, the total amount of counseling time, in hours, for each program is:

<u>Type of Counseling Service</u>	<u>Herrick</u>	<u>West Oakland</u>	<u>Eden</u>	<u>East Oakland</u>
Individual	446	441	1127	436
Family	0	21	100.5	0
Group	102	220	0	60
Vocational	0	17	30	0
<u>Recreational</u>	<u>3</u>	<u>12</u>	<u>0</u>	<u>0</u>
TOTAL HOURS	551	711	1257.5	496

Dividing the total number of hours that the counseling staff from each program spent providing counseling by the total number of hours available to the staff for counseling, the following percentages were found:

Herrick	551	1365 = 40%	of available time spent in providing counseling
West Oakland	771	3120 = 23%	
Eden	1257	2730 = 46%	
East Oakland	496	1170 = 42%	

As mentioned in the sections of this report that dealt with each program, counselors have other client-related tasks to perform besides client counseling. No judgment is being made about the adequacy of time spent providing counseling. However, it should be noted that differences found cannot be attributed to the programs' being county-operated or contractual, but may be traced to the administrative capacity of each program to organize and apply counseling services when and where needed.

County/Contractual Services

The preceding quantitative indices for the methadone programs do not suggest a strong argument in favor, or against, the program being county-operated as opposed to contractual. The county programs did have administrative problems that were contributed to by the county system. For example, the reorganizations of the methadone programs created turmoil, staff turnover, and client unrest. Eden had four directors in less than one year. Also, county programs have difficulty in determining their fiscal status and sometimes have hiring problems when county "freezes" or related procedural roadblocks appeared. On the other hand, West Oakland, a contractual program, has rather severe administrative problems. Conflicts in lines of authority and program responsibility have contributed to operational deficiencies.

Superior administrative management should be the result of any decision to change county operated methadone programs to a contractual form of service delivery. The chaos that is created in a treatment environment when management does not make an adequate contribution materially affects the efficiency and the impact of the program.

In summary, except for Herrick's methadone program in which management efficiency appeared to be very good, all of the other methadone programs had some efficiency problems. We have recommended specific improvements. The data did not reveal any factors that would suggest, unequivocally, that the county programs should become contractual.

Recommendations

There are some recommendations that we would like to add that do not relate to specific programs, but rather to the programs as a whole. These are made to cover areas in which the county should increase its level of involvement in an effort to foster better operations.

1. Finance technical assistance for programs in the area of recordkeeping and report preparation.
2. Establish specific program objectives which each program is to achieve in a determined time period.
3. Monitor the implementation of written operating policies and procedures.
4. Implement an accounting system which is capable of producing historical data on productivity and cost for the county-operated programs in a timely manner (within 30 days).
5. Review civil service job descriptions to determine the adequacy of job descriptions for personnel in county-operated methadone programs.
6. Insure the existence and operation of client grievance procedures dealing with program services.
7. Provide technical assistance to develop and implement training programs for all levels of program personnel.

APPENDIX

1. Program Questionnaire to Solicit Background and Operational Information about the Methadone Program.

I. General Features

- A. Program Name _____
- B. Program Address _____
- C. Program Telephone Number _____
- D. Program Director _____
- E. Program's currently funded contracts and budgets (please submit a copy of your program's current contracts and budgets - if no formal contract exists for your program, please submit the standard working agreement and guidelines along with your program's budget).

II. Program Goals and Objectives

A. Statement of program's philosophy (please state - if you have an official Statement of Purpose please submit a copy).

B. Program Objectives and Goals (please state).

1. Services provided to meet objectives and goals (please list).

III. Treatment Matrix - Current Fiscal Year

A. Number of treatment slots approved _____

B. Number of treatment slots budgeted _____

C. Number of clients on waiting list _____

D. Number of treatment slots currently filled _____

IV. Target Population

- A. Primary community(ies) served _____
- B. Population estimate of community(ies) served _____
- C. Describe geo-political characteristics of community(ies) served.

D. Characterize the client target population served by your program:

Average age: Male _____ Female _____

Sex: % Male _____

% Female _____

Ethnicity: % Black _____

% White _____

% Chicano _____

% Asian _____

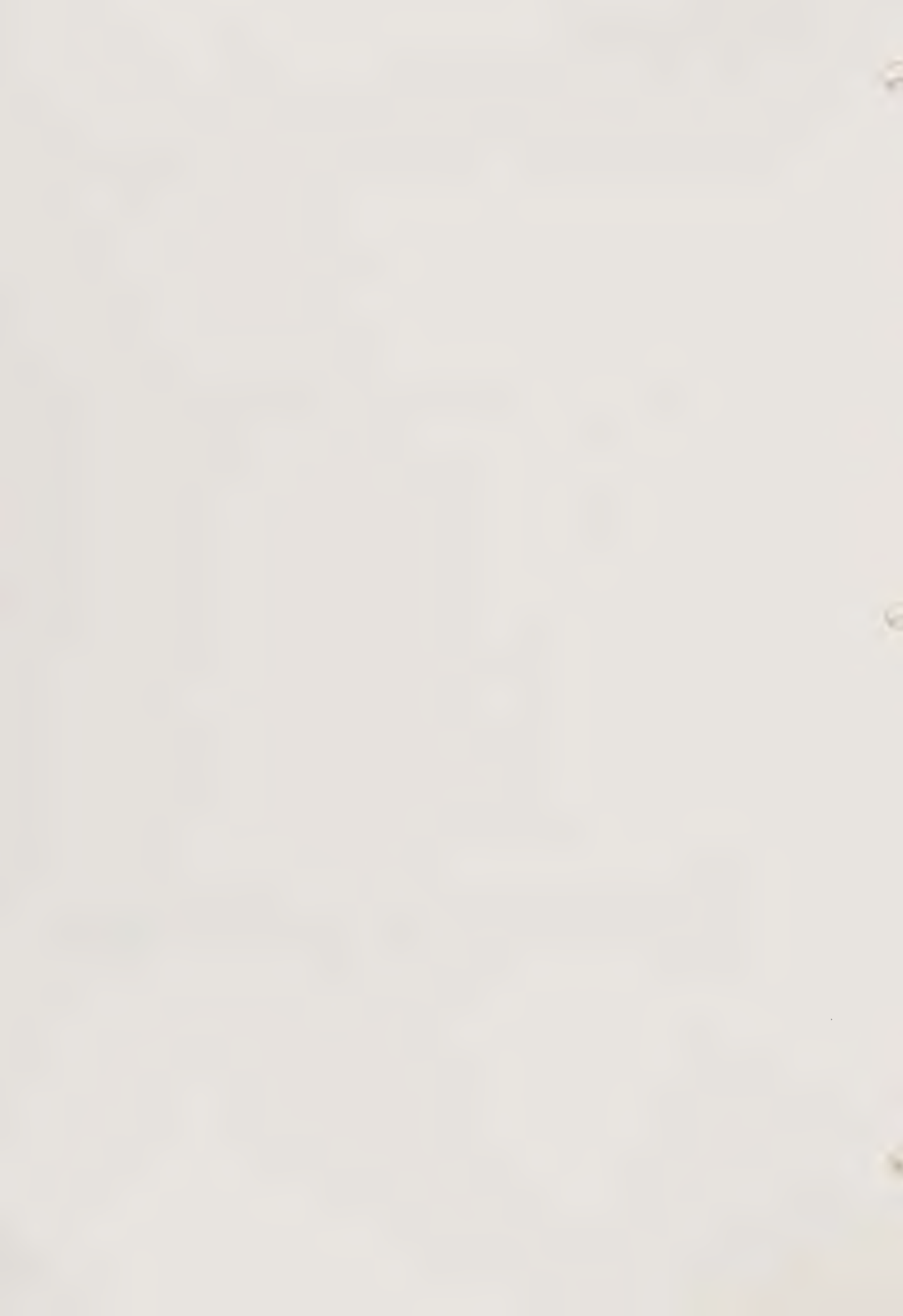
% American Native _____

% Indian _____

% Other _____

V. Records

(please submit the type of forms you use for various record-keeping
i.e. client records (treatment plan format), fiscal records, data
collection records, medical records, other)



VI. Policy Making Body

A. Membership - list of Board of Directors (please submit) (indicate sex, ethnicity, occupation)

B. Function of Board - please state

VII. Organizational Chart

Please submit a copy of organizational chart.

VIII. Program Staffing

A. Program job positions (please submit a copy of each job description for budgeted positions; half-time and full-time).

B. Staff resumes (please submit).

C. Date of employment for each staff person.

D. Staff positions not filled.

E. Employee Handbook (please submit if available)

F. Personnel Policies (please submit)

G. Affirmative Action Policy (please submit)

H. Staff: client ratio - please state

IX. Staff Training

A. Describe in-service training program.

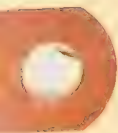
B. List consultants to your program.

X. Clients

A. Admission criteria - please state

B. Termination - please state conditions for termination

C. Client appeal procedure - please state



AGENCY
AND
PROGRAM DIRECTORS

COMMENTARY
AND
OBSERVATIONS

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Health Care Agency

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Program Directors



OFFICE OF THE PUBLIC DEFENDER

ALAMEDA COUNTY COURTHOUSE
1225 FALLON STREET
OAKLAND, CALIFORNIA 94612
874-5353

JAMES C. HOOLEY - PUBLIC DEFENDER

February 23, 1976

Office of Program Evaluation
Administration Building, Room 458
1221 Oak Street
Oakland, California 94612

Attention: Matt Golden
Program Director

Gentlemen:

I have reviewed your Analysis of Alameda County's Drug Program Delivery System and your report on the Efficiency and Effectiveness of Four Methadone Programs.

This was a monumental amount of work! I commend your office on the great detail in which they conducted these studies.

The comparisons of the programs were candid and thorough.

I'm pleased to have been able to peruse the fruits of your labor. My congratulations for a difficult task well done.

Very truly yours,

JAMES C. HOOLEY
PUBLIC DEFENDER


Duane A. Sciford
Assistant Public Defender

DAS/lmm

Probation Department

of Alameda County

400 Broadway, Oakland

Area Code 415
874-7586

INTERDEPARTMENTAL COMMUNICATION

DATE: January 27, 1976

TO: Mathew Golden, Director,
Office of Program Evaluation

FROM: Larry W. Walker, Director,
Division of Adult Probation

RE: Report on Alameda County's Drug Program Delivery System
and the Efficiency and Effectiveness of four Methadone
Programs

In general, the studies of the four Methadone Maintenance Programs and Drug Program Delivery Systems in Alameda County are informative in their scope and thoroughness.

The comparative evaluation of the efficiency and effectiveness of the Methadone Maintenance Programs are generally consistent with the Probation Department's experience with the respective programs. Although methadone maintenance is considered an invaluable resource for selected defendants, it is viewed generally as a "last resort" and clearly as a maintenance effort and not as a treatment modality. Our experience with probationers on methadone maintenance is consistent with the findings of the evaluation team. There is clearly a reduction in the use of heroin by the participants who remain in the programs. There is also a reduction in the number of known criminal offenses which directly correlates with the reduction in heroin usage.

The comments which follow are directed at Part I of the report, the "Analysis of the County's Drug Program Delivery System":

1. Recommendation 3 - Page 3, "No county or private program employee should serve on the Advisory Committee on Drug Abuse".

We agree that ACDA should be composed of members who do not have a vested interest in funding. However, it is critical that the committee provide a vehicle for input from the Criminal Justice System.

2. Recommendation 4 - Page 3, "Health Care Services should be responsible for all treatment funds that flow through the County and Probation should contract with them for treatment slots".

Funding through a single source should provide more stable and predictable funding and financial management. The efficacy of this proposal would seem to depend to a large extent on the make-up of the Advisory Committees, and the effectiveness of the Drug Coordinator/CAO to negotiate and effectively settle any differences regarding contracted treatment slots to insure that Criminal Justice needs are met.

3. The report indicates on Page 11, under the section entitled, "Multi-Funding" that Health Care Services Agency reserve slots in treatment centers to avoid the situation in Methadone Clinics when waiting lists are too long to permit effective placement of pretrial clients.

- a. With the exception of two out-of-county programs, (Delancey Street and Center Point) there have been no waiting lists for entry into t.c.'s.
- b. Regarding pretrial placement in methadone programs, this is frequently not the most practical alternative during the pretrial stage. Even when TASC had an unlimited number of methadone slots available at Herrick Hospital, they were rarely, if ever, used for pretrial placement. The procedure for entry into a methadone program usually takes from two to four weeks. If the client is in custody it may be difficult to provide transportation to the methadone clinic to undergo the physical examination.

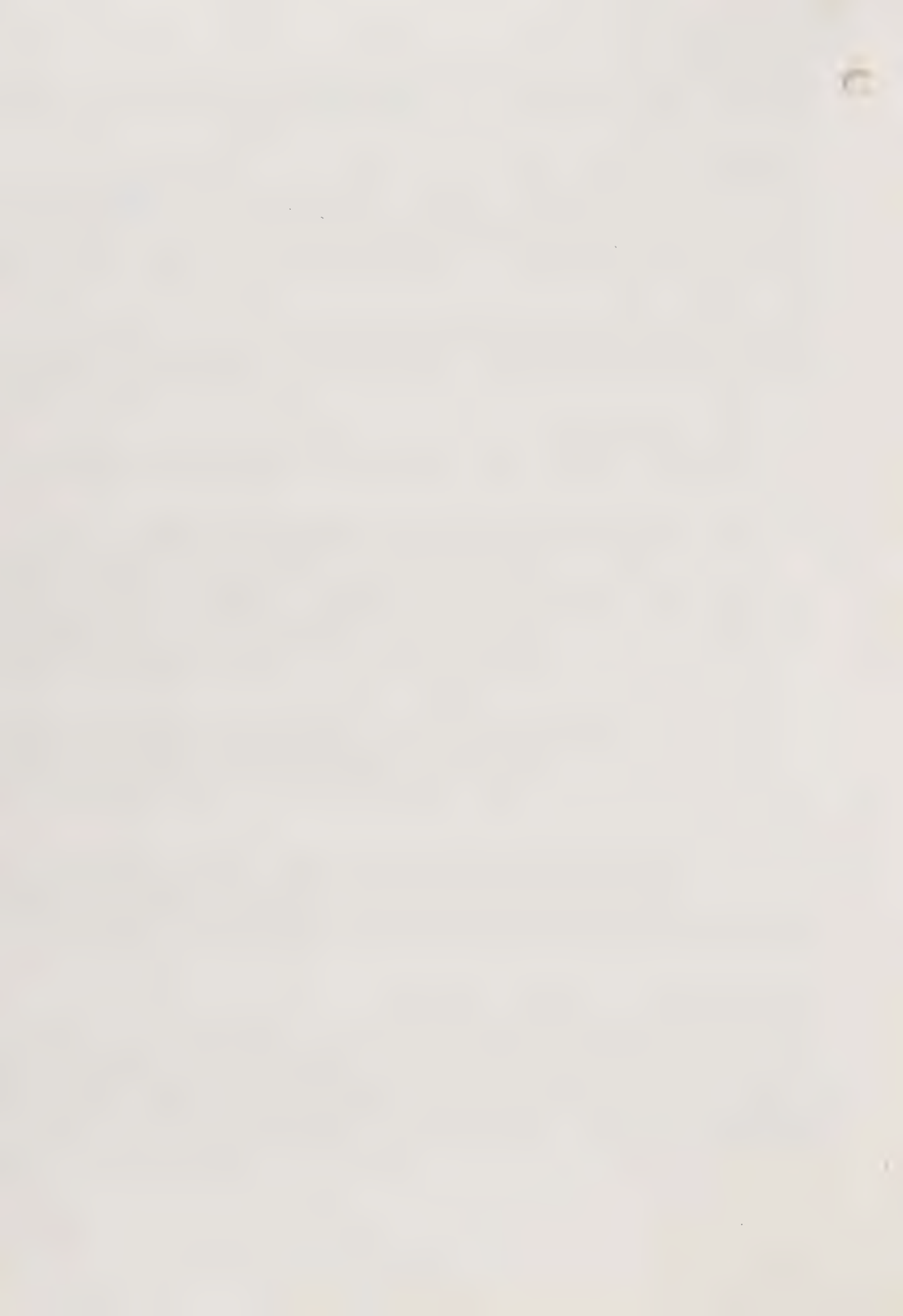
Further, if the defendant is in a methadone maintenance program during the pretrial phase, and then is sentenced to jail, detox must then begin immediately since the Federal law precludes methadone maintenance in a county jail beyond twenty (20) days.

4. Auditing Services - Page 16

We support the recommendation regarding the need for assistance in fiscal management of the programs. If adequately staffed, we agree with the recommendation on Page 17 that the Auditor analyze the procedures in Santa Clara County regarding their feasibility in the Alameda County System.

5. Recommendations to Court - Page 20

The report states that the Probation Department was not recommending methadone maintenance for unsentenced defendants who wanted in the program. Some of the problems associated with methadone maintenance for pre-sentence defendants were commented on earlier. However, methadone maintenance is recommended when we are certain it is appropriate, but generally not until other treatment modalities have



have proven to be unsuccessful. It is our experience that a defendant who wants methadone maintenance is not necessarily a good candidate for the program.

6. "Splitees" from Programs - Page 21

The report indicates that persons who have left the programs without permission are not systematically reported to the Court. The t.c.'s are required to notify the Probation Department of "splits" and our experience is that defendants who leave the various programs without authorization are reported to the Court by Adult Probation, or Pretrial Services, depending upon the defendant's current status.

7. Treatment Priorities - Page 33

While we agree with TACDA that priorities for drug program funding in Alameda County should focus on therapeutic communities, we question Paragraph 4 on Page 33. In our experience, out-patient programs for heroin users have proven to be of very limited value and conversely the longer an individual stays in a residential drug treatment program, the better are his chances for success.

LWW:mps

cc: Robert D. Shaner

COUNTY OF ALAMEDA

office of the
AUDITOR-CONTROLLER

DONALD M. PARKIN
Auditor Controller

HERBERT W. COCHRAN
Chief Deputy Auditor

Telephone (415) 874-7295

Administration Building / 1221 Oak Street / Oakland, California 94612

To: Matt Golden, Director, Office of Program Evaluation

From: J. H. Vaughns, Ad Hoc Committee member, Deputy Auditor, Alameda County

Subject: Comments involving Auditing Services from the Report, "An Analysis of Alameda County's Drug Program Delivery System and the Efficiency and Effectiveness of Four Methadone Programs"

Date: February 18, 1976

My comments as expressed are based on my involvement in business development, as well as community organizational development, prior to and during my tenure with the County. These reflections have been present for some time now, and I share them in hopes that consideration would be given to them.

With experience in the area of business development earned during the years in which the Small Business Administration unsuccessfully brought many minorities into the mainstream of business activity, one key problem persisted in the majority of cases relating to business failures - lack of management expertise.

The same situation exists here. The fact an organization does not maintain an adequate accounting system is not basically due to the lack of their accounting expertise, or the fact that they will not divert program funds to administrative needs. It is their inability to comprehend good management practices.

In small operations, be they profit making or nonprofit, the individual involved must be well qualified in all the management functions, or be aware of one's limitations and understand the need to compensate for the limitations.

Further recognition must be given to limitations in funding and the need to be very efficient with those funds throughout the operation. The luxury of making mistakes is the pleasure of big businesses who have the reserves to experiment.

It is important to understand the vast difference between big business and small operations.

Awareness of the total operational needs is another key to success. You have to be aware of when to apply various management functions. You must know when to be a personnel officer, or when to review operations to measure progress towards the attainment of goals, or when it becomes necessary to apply technical adjustments or changes to your program operation.



Once we begin to address this problem, then we can fully understand many of the problems that exist within the community-based organization concept.

Many of the community-based corporations are brought into existence without the necessary assets and resources to conduct a business-type operation. One inherent problem in such cases is the lack of adequate cash flow.

This is one major problem that will immediately signal potential disallowances, which invariably results in the operation folding and/or the expenditure of a great deal of time on the part of County individuals to resolve the situation.

What is necessary if we, the County, are going to continue to fund the community-based corporation is a more selective screening process.

This screening process should be designed to reveal an entity's ability to operate within the confines of the laws of the State of California, not just for the purpose of the funding. It should reveal the management competence within the organization and should look at its financial stability and potential.

If the purpose of the contract is to establish an entity to provide specific services, then the contract should be tailored to accomplish the stated purpose. Many disallowances are the result of the contract saying one thing and the contractor doing another thing. This is definitely the result of poor communication.

Communication is a vital factor when two or more parties begin to structure contractual arrangements. Without real comprehension of the other's intentions, your successes are limited. And when you begin to multiply the parties involved (number of channels within County government), distortion of facts begin to unfold very rapidly. Acceptance of responsibility for distorted facts is difficult and a hard defense line is created that prolongs the process of resolving issues.

In summary, we will always be faced with expressed concerns of individuals if we attempt to solve those issues expressed rather than analyzing the whole process from both sides (organization and county) to determine why those concerns were created.

If we don't improve our screening process, then we must alter our contractual relationship to meet those needs of the desired operation, dealing with all their potential problems.

Finally, we must deal with the communication process. It is evident from the methadone report response that we have a communication problem.

As the Supervising Auditor of the Grants Audit Section for the Auditor-Controller of Alameda County, I believe the suggestion that visiting Santa Clara County can be a rewarding experience, but its value as a problem-solving mission is questionable.

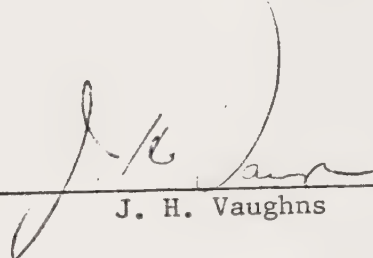
We evaluate new organizations within forty-five (45) days of the contract execution date for the express purpose of determining their ability to meet the contractual conditions.

February 18, 1976

It is not our role to set up and maintain bookkeeping systems. Such a role would impair our ability to remain independent in carrying out our audit responsibility. There are many accounting systems available at a nominal cost. The problem area is in the maintenance process which may result from lack of expertise or spreading one's self too thin over the total operational picture. There are professional firms and individuals available to maintain accounting systems.

I agree we should hold workshops with contractors. These sessions should involve those county departments that directly deal with contractors in a question and answer session on procedures. However, the County should not be expected to hold training sessions to teach the rudiments of accounting and fiscal management.

The fiscal requirements of federal or state funded programs are set forth in manuals issued by the grantor agencies. The provisions embodied in these manuals apply to grant funds passed through the County to its sub-contractors. Accordingly, our audits of the sub-contractors are made pursuant to the provisions of these federal or state manuals. Rather than publishing an additional fiscal affairs manual, we believe that when the contract is awarded, the sub-contractor should be provided either a list of applicable federal or state publications or actual copies of the publications.



J. H. Vaughns

JHV:bjs



METHADONE MAINTENANCE: A CRITIQUE

Submitted by
Nancy Jo Albers



The problems inherent in the use of methadone for maintaining heroin addicts as well as the lack of significant research on the long-term effects of methadone must be accurately reported when evaluating methadone maintenance programs. There are also ethical/political issues related to government funded and sponsored programs that addict citizens and sustain their addiction which require thoughtful discussion. A review of some of the issues and problems related to methadone maintenance follows.

Incidence of Drug Abuse During Methadone Maintenance and Following Detoxification

Studies of clients while on methadone maintenance programs reveal that the frequency and types of drugs being abused are of significant concern. 119 clients¹ stabilized on methadone for a minimum of one year composed a group studied over a 9-month period at the Narcotic Addict Rehabilitation Program in Philadelphia (N.A.R.A. Title IV Project). This study found that heroin was being abused 35.3% of the time, barbiturates 11.5% of the time, and amphetamines 14.4% of the time. No methadone found in the urine occurred 17.4% of the time. Overall, drug abuse occurred 59% of the time while clients were being maintained on methadone. The incidence of drug abuse was much greater than what was anticipated.

The results of a study done in San Francisco revealed that the probability of an addict spending one year in remission from heroin use while being maintained on methadone is less than ten percent.²

Few clients ever successfully withdraw from methadone and refrain from reverting back to heroin. In a follow-up study³ done in Philadelphia it was found that 81% of the clients who detoxified from methadone relapsed to the use of heroin within a one month period.

Long-Term Psychological and Physiological Effects

There is no dispute that methadone is a dangerous addicting drug. However, the long-term physiological and psychological side effects of methadone remain for the most part unknown. Chambers, Brill, and Langrod raise a number of questions about possible side effects of the prolonged use of methadone. They include:

1. "What is the psychological⁴ impact on the addict-patient during long-term maintenance therapy?"

Some evidence exists which shows that for long-term methadone clients depression and anxiety increases after two to three years on methadone.

2. "What are the physiological impairments experienced during long-term maintenance therapy?" The authors state that there is anecdotal evidence that long-term clients maintained on their normal daily doses will unpredictably become sedated; that is, without forewarning clients will dose off, i.e. nod.
3. "What are the cognitive impairments experienced during long-term maintenance therapy?"

According to the authors cognitive impairment such as attention span, memory recall, and abstract problem solving have not significantly been researched.

In studies done at the Addiction Research Center in⁵ Lexington, Kentucky, it was determined that the chronic administration of narcotics creates a physiological disorder called protracted abstinence. Through these studies it has been found that following long-term opiate use (i.e., methadone) the physical effects of withdrawal symptoms persist six to seven months after detoxification. This physiological disorder is thought to be associated with the relapse to the use of heroin. Necessary research needs to be developed to determine whether methadone maintenance adversely affects the relapse to heroin use as well as affecting social adjustment following detoxification.

The stated questions raise serious issues. Methadone maintenance has been an "acceptable" modality for a number of years in the treatment for heroin addicts; yet significant research does not exist to answer the questions facing us.

Methadone Diversion

Methadone originating from government supported sources is being illegally diverted and sold on the street. Current data exists confirming that the illegal diversion of methadone is extensive and constant.⁶ In a study done in New York with ninety-five active heroin addicts (not in jail or in treatment for at least six months prior to interview) 41.1% reported buying methadone from clients enrolled in various methadone programs.

Diversion creates the problems of methadone being sold for other drugs, addicts treating themselves while using multiple other drugs, overdoses, methadone becoming a drug of primary addiction, and the use of methadone by experimenting drug persons.

To quote from Isbell and Vogel: "Morphine addicts like methadone⁸ because of the relief from psychic and emotional discomfort which it gives and because it will suppress signs of physical dependence when substituted for morphine. These qualities make methadone a particularly dangerous drug....

The veteran morphine addict is skilled in ways of obtaining drugs illegally and has few scruples about introducing non-addicts to the use of the drug.... Addiction to a drug which is popular with morphine addicts is likely to spread much more rapidly than addiction to a drug which is liked only by people who have never been addicted to morphine....Furthermore, addicts repeatedly relapse to the use of morphine long after withdrawal from methadone..."

Role of the Government

The role of the government in relationship to methadone maintenance is of serious concern. Any government funded and sponsored program which addicts its citizens is dangerous. Essentially people become addicted wards of the State and dependent upon the government to sustain their addiction. The rights of the individual are in jeopardy when the government is in the position of sustaining ones addiction. A more appropriate role the government could play is in the area of providing adequate housing, schooling, jobs, and drug-free programs with supportive services for those people addicted.

Summary

Issues of crucial concern related to methadone maintenance remain unresolved. Immediate attention to these issues is required before giving further acceptance to this treatment modality. These issues include the following:

- The frequency of heroin and other drugs being used while clients are maintained on methadone.
- The low success rate of clients being detoxed from methadone.
- The lack of knowledge and significant research concerning long-term psychological and physiological effects of being maintained on methadone.
- The problems related to the illegal diversion of methadone.
- The role of the government in sustaining its citizens addiction.

Decision makers of the governmental policy-making body (Federal, State, and local) the legal profession, the medical profession, and the Health Care Services profession must give thorough consideration to the issues and questions raised before determining policy related to methadone maintenance and, consequently, the future addiction of individuals to methadone.

References

¹Carl D. Chambers and W. J. Russell Taylor, "The Incidence and Patterns of Drug Abuse during Maintenance Therapy," Methadone: Experiences and Issues, New York, Behavioral Publications, 1973; pg. 122.

²Beach Conger, "Evaluation of a Methadone Maintenance Program," National Conference on Methadone Treatment, Vol. IV, pg. 533.

³Arthur D. Moffett, Irving G. Soloway, Marcia X. Glick, "Post-Treatment Behavior Following Ambulatory Detoxification," Methadone: Experiences and Issues, New York, Behavioral Publications, 1973, pg. 221.

⁴Carl D. Chambers, Leon Brill, and John Langrod, "Physiological and Psychological Side Effects Reported During Maintenance Therapy," Methadone: Experiences and Issues, New York, Behavioral Publications, 1973, pgs. 169-170.

⁵Leon Brill, "Opposition to Methadone Maintenance Therapy: A study of Recent Sources of Criticism," Methadone: Experiences and Issues, New York, Behavioral Publications, 1973, pgs. 320, 321.

⁶Peter Walter, Barbara Sheridan, and Carl Chambers, "A Study of Illicit Availability," Methadone: Experiences and Issues, New York, Behavioral Publications, 1973, pgs. 174-176.

⁷Ibid., pg. 350.

⁸Harris Isbell and Victor Vogal, "The Addiction Liability of Methadone (Amidone, Dolophine, 10820) and its use in the Treatment of the Morphine Abstinence Syndrome," Methadone: Experiences and Issues, Carl Chambers, Leon Brill, New York, Behavioral Publications, 1973, pgs. 50-51.

ALAMEDA COUNTY
HEALTH CARE SERVICES
AGENCY



WID ODELL, Agency Director

FAIRMONT HOSPITAL
15400 Foothill Blvd.
San Leandro, California 94578

February 25, 1976

The Honorable Board of Supervisors
Administration Building
1221 Oak Street
Oakland, California 94612

Gentlemen:

Subject: Health Care Services Agency Comments: Office
of Program Evaluation Analysis of the Drug
Delivery System and Alameda County Methadone
Maintenance Programs

The following comments are offered by the Health Care Services Agency.

PART I: Report Titled "Analysis of the Drug Delivery System in Alameda County"

Overall, we believe the evaluation to be skillful in identification of existing problems and helpful in recommendations. Of course, as is always the case under time constraints, some errors of fact or misunderstandings occurred.

The first two sections, dealing with Policy and with the Role of the State, are essentially accurate. The report's analysis of the role of the State provides good insight into the complexities of drug abuse administration and policy formulation which are predicated on State and Federal actions. While we concur with the recommendation of Section II, that

"Alameda County needs to develop a formal communication network with the State so that crises can be better avoided. The State needs to be notified in writing, not just when decisions create local confusion and hinder treatment effectiveness, but also when changes in the system can prevent future problems"

we believe it necessary to point out that there has been concerted County effort to make the Federal and State funding authorities aware of problems. County actions included activities by Board members, staff of Health Care Services, County Administrator and Probation, and efforts by the County's Washington, D.C. and Sacramento Legislative Analysts. We trust that with development of comprehensive policy guidelines, the communication network with the State will continue to improve.

Section III on Planning and Priority Setting discusses the County Plan, planning coordination with Criminal Justice, and priorities. About the current County Plan, the report concludes that

"statistics were not used to draw a picture of the true needs in the County."

We agree that this area needs improvement. Indeed, it needs improvement State-wide. In the just released California Plan for 1976, the very first page contains the following: "current available drug abuse data . . . (does) not, therefore, permit a detailed analysis but is presented for informational purposes." This same California Plan comments that "assessing the drug problem (is) a challenging task."

The recommendation of Section III, that

"A 'Criminal Justice' plan needs to be prepared by the Probation Department with input from city police, the District Attorney's Office, the Public Defender's Department, Probation Officers, and most importantly, the Court. This document should be blended with the Health Care Drug Plan so that a single comprehensive document is used as the basis for decision"

is one with which the Agency concurs and one which we are presently addressing.

In discussion of priorities, the evaluation report (pp. 15-16) quotes a 1975 report prepared by Pacific Institute for Research and Evaluation. These quotes should be read in the context that the Alcohol and Drug Abuse Services Office had been operational and fully staffed for less than nine months at the time the Pacific Institute study was done, and that the planning process for this coming fiscal year has been developed to be responsive to the report's suggestions.

Section IV on Funding Mechanisms provides an analysis of the drug abuse funds in Alameda County. The first recommendation, that

"The administrative responsibility for all drug programs that contract with the County should rest with the Health Care Services Agency to assure fiscal and performance consistency"

is completely acceptable to this Agency.

The second recommendation, that

"the lack of court diversions or conditional probation slots in the programs, combined with an expressed interest on the part of the Probation Department to have such slots available as an alternative, points out the need for adequate comprehensive needs assessment (i.e., how many people would the Court divert to methadone programs?) and coordinated planning"

is acknowledged and is part of the Agency's overall recommendation.

The third recommendation, that

"the Office of Alcohol and Drug Abuse should continue to more aggressively pursue the concept of planning and funding on a regional basis with neighboring counties"

is already being implemented by this Agency.

The final recommendation of this section, that

"The Drug Coordinator should give a high priority to the development of an evaluation mechanism and request funds for it from the Board of Supervisors"

is one that was implemented by this Agency in the 1975/76 budget year. Unfortunately, because of the funding deficiency in drug abuse, the amount earmarked for evaluation had to be cut from the County Administrator's approved budget.

Section V dealing with Advisory Structures contains six recommendations regarding the Technical Advisory Committee on Drug Abuse. The Agency wishes to point out that these recommendations have serious policy implications for all Commissions, Board, and Committees throughout the County.

Section VI on Support Services recommends that:

"The Office of Alcohol and Drug Abuse should not provide support services to the programs. However, it is incumbent and on the County to clarify all procedures and requirements mandated by the County."

"Contracts should contain provisions for assistance in support services."

"The Health Care Agency should act as a resource to programs in the selection of various forms of assistance."

The Agency concurs. It should be noted that Alcohol and Drug Abuse Services' initial emphasis was on providing support services to the community because there were so many new programs just starting up. These programs are now well established and the staff previously utilized for support services can now be re-directed.

Section VII on the Criminal Justice System is essentially correct. The recommendations of this section, that

"Probation and Health Care Services (should) explore the feasibility and potential benefit of re-establishing such a program (as Santa Rita Drug Program)"

"The courts need to receive more factual information as to the impact of drug programs and they need to be more active in availing themselves of that information."

"The Criminal Justice System and Health Care Services need to plan more actively together, and their planning should include input from the courts"

are concurred with by the Agency. The Pre-Trial Services Coordinator's Office is providing the factual information required.

The final section of the report (Section VIII on the Office of Alcohol and Drug Abuse Services) contains a number of recommendations which we believe require comment. While we agree that

"there are many inherent conflicts built into the role and basic mission of the Office of Alcohol and Drug Abuse Services"

we do not agree that these conflicts can necessarily be resolved simply by changing the structure of administration. To some extent, these conflicts are basic to the coordination, management, and operation of any service delivery system which attempts to blend both County and community based programs.

The report identifies a number of dichotomies in the role of Alcohol and Drug Abuse Services. Our approach over the past year, including reorganizational efforts, has been directed toward these concerns. We believe that resolution of the specific conflicts pointed out in the report will occur as a result of the recommendations contained in this letter; specifically, implementation of the following: (a) discontinuation of support services; (b) establishment of an inter-agency drug planning unit; (c) provision of external, independent evaluation.

The report recommends:

"That a comprehensive on-going needs assessment be designed and implemented and that it be supported by an integrated information system that coordinates all present statistical and subjective reporting."

"That an annual, comprehensive County-wide Drug Plan be developed that states and describes program needs, goals, and objectives; the plan would describe the total program regardless of agency responsibilities."

"That a list of program priorities with alternative sources and methods of funding be incorporated in the above plan and be presented to the County Board as part of the yearly budget process. Funding decisions should reflect the priorities in the plan."

The Agency concurs. Four alternatives are proposed by report as potentially workable solutions to provide a framework within which these recommendations can be implemented. The alternatives offered are:

- I. The County Administrator's Office
- II. Continue Present Model
- III. Health Care Services Agency
- IV. The Inter-Agency Ad Hoc Coordinating Committee

Of these available options, the report recommends either Alternative I or Alternative IV.

The Agency does not support this recommendation. As we pointed out in our earlier review of this report, removing the position of Drug Abuse Coordinator from the Health Care Services Agency has the following major disadvantages:

- a. Drug abuse is a health problem and should be administered in a health agency. The State law actually designated the Local Mental Health Director, unless the Board of Supervisors chooses to appoint someone else, and that someone else can only be the Health Agency Director or the County Administrator.
- b. Federal policy (the National Institute of Drug Abuse) requires that monies flow through and are administered by health agencies throughout the country.
- c. The recommendation would divide and diffuse accountability and authority splitting it among the Drug Coordinator, the Health Care Services Agency, and the Advisory Board.
- d. Eighty-four percent of the County-administered drug funds flow through the Health Care Agency.
- e. The recommendation assumes that drug funding is stable. Drug funding in any fiscal year may vary greatly, depending on State and Federal priorities.
- f. Alcohol and drug programs fit well together in an effective and efficient manner. Their treatment modalities are very similar. We have recently combined the medical back-up of both drug and alcohol into one unit. Organizations such as the California Medical Association have combined drug and alcohol into a single substance abuse committee. There is a trend throughout all counties in California to establish a Division of Substance Abuse rather than split divisions, one for alcohol and one for drugs. There is efficiency and flexibility of staffing. To administratively divide alcohol and drugs would be more costly.
- g. The present administration for alcohol and drugs has done an excellent job in working with the advisory boards, the community groups, Federal, and State officials. The program has expanded with increased funds.

In summary, the Health Care Services Agency believes that the County is best served by maintaining the Alcohol and Drug Abuse Office as a single unit. We also believe that it is best placed within Health Care Services so that responsibility and authority can remain together.

We believe that implementation of either Alternative I or IV would prove to be expensive, would further fragment services, and would diffuse leadership, responsibility, and accountability.

Instead of these alternatives, the Health Care Services Agency proposes that the Board consider what we believe to be a more workable solution to the need for provision of comprehensive County-wide planning, comprehensive needs assessment and structured priorities.

It is recommended that the Board authorize creation of a formal Drug Planning Unit, inter-agency in nature, with delegated authority to:

- design and implement a comprehensive on-going needs assessment.
- develop an annual, comprehensive County-wide Drug Plan responsive to all segments of service delivery.
- develop a comprehensive list of program priorities with alternative sources of methods and funding to be presented to the Board as part of the yearly budget process.

It is recommended that the Drug Planning Unit be chaired by the current Assistant Agency Director, Alcohol and Drug Abuse Services, and that the members include policy-level representatives from Probation, Pre-Trial Coordinator, the Schools Department and the County Administrator's Office.

A model for this inter-agency group already exists, on an operational coordinating level, with slightly different membership, in the form of the Inter-Agency Ad Hoc Coordinating Committee.

It is recommended that necessary full-time staff be provided to the drug planning process by redirecting staff resources in Alcohol and Drug Abuse previously involved with providing support services to community groups. With no increase in cost, this will assure the adequate professional level necessary to carry out the broad assignment in needs assessment, planning, and priority setting stemming from the inter-agency drug planning unit. As is pointed out in the report, adoption of this alternative would require designating the drug planning unit as a formal body and delegating the authority for producing a program plan. As recommended in the report, the inter-agency unit would be the interaction point among the program and various citizens and provider inputs for the planning process.

Adoption of this alternative will not increase the cost of administration, and will provide a viable mechanism for meeting the recommendations on comprehensive planning and priority setting. In addition, the advantages listed under Alternative IV are also applicable here, i.e.,

"It utilizes an interagency mechanism for the design and evaluation of a program which also is interagency in terms of service delivery."

"It enhances coordination, understanding, and communications in the most important areas 'what are the needs,' 'what should we do about it,' and 'what are our priorities.'"

"Positive agreement among the involved agencies on the basis described in point 2 will minimize the need for operational coordination."

"It tends to focus the planning process by having all actions relate to one committee through full-time staff."

"It provides a forum for discussion of various agency priorities within the context of preparing a comprehensive plan and evaluating total program results."

"It may generate more commitment to program administration since it would generate agreement on what everyone was trying to do."

"The County Board could be assured that it would represent board input in the planning process."

PART II: County Methadone Maintenance Programs

A. Program Efficiency

In general, the Agency concurs with the recommendations contained in this section of the Methadone Maintenance Report. However, it should be noted that the report's comparison of the ratio of actual cost to an accepted standard of \$1500 is incorrect. This was the amount used by the Special Action Office for Drug Abuse Prevention in October, 1973. The standard was increased by that office to \$1700 in July, 1974. All direct NIDA funded contract programs operate on this \$1700 figure.

It also should be noted that the ratios reported for the County-operated methadone maintenance programs were based on conditions which existed during the time of the evaluation. Since that time, the staffing patterns have been substantially changed in accordance with the approved Alcohol and Drug Abuse reorganization plan, and consequently all ratios have been improved. Additionally, the reorganization will reduce the unit cost per occupied and approved slots in both of the County-operated methadone programs.

The report indicates that the medical director of East Oakland was appointed to the position of medical director of both East Oakland and Eden Methadone clinics and that this new director possessed no management or administrative experience. The intent of this reassignment was simply to place both programs under the same medical direction and to reduce the overall physician time in both clinics. Full-time management and administration is provided, not by the medical director, but by two on-site program administrators (one in each clinic).

B. Program Impact

The Agency concurs with the recommendations in this section, i.e.,

"All four methadone programs be kept open with their existing slots"

"Screening and case review procedures be tightened up within existing methadone programs before deciding to increase slots"

"Programs should endeavor to develop short and long term goals with their clients, and periodically review these goals."

"Alternative modes of drug treatment need to be explored more thoroughly before deciding to increase the capacity of any existing drug program"

however, we believe that much of the discussion and rationale behind the recommendations are purely academic and not applicable to the methadone maintenance programs in the County.

The discussion under the fourth recommendation, particularly with respect to the experimental use of LAAM or heroin maintenance as alternative modes of drug treatment is inappropriate at this time. Appropriate State and Federal agencies have been contacted regarding possibilities in Alameda County, but the cost of administering research programs for the experimental use of heroin maintenance or LAAM are far too costly for the County to undertake.

Finally, any conclusions based on statistical analysis of data from the four programs should be viewed with extreme caution. There are a number of basic errors in the report's statistical methodology.

The Honorable Board of Supervisors
February 25, 1976
Page 10

In general, these two reports on Delivery System and on Methadone Maintenance have been most comprehensive and have shed a great deal of light on the complexities of the drug abuse problem and program within Alameda County.

Very truly yours,

A handwritten signature in dark ink, appearing to read 'Stewart B. Gross', is written over a horizontal line.

Stewart B. Gross, M.D.
Deputy Director

SBG:CNL:js

cc: Loren Enoch
County Administrator



herrick memorial hospital

Your voluntary, nonprofit community health center 2001 Dwight Way Berkeley, CA 94704 415 / 845-0130

HERRICK-BERKELEY COMMUNITY METHADONE PROGRAM

January 28, 1976

Shayna Stein
Office of Program Evaluation
1221 Oak Street, Room 458
Oakland, California 94612

Dear Ms. Stein:

The recent evaluation done by the team from Alameda County was well done and well structured. The team members were pleasant and unintrusive. It seems as though a lot of time and effort was put into it in order to give an in depth description of the functions of our program. There were some recommendations made which the program staff has felt would be desirable. I would like to go over the list and respond to them.

1. A more in depth social history

Upon initial interview often you get untrue answers because of the low trust level. This information has little input for treatment of clients. It does have value for research purposes. More useful information could be gathered after the client has been in the program, and more trust has been established, where the answers are more honest and the questions less threatening. The evaluation team offered to assist in preparing a social history form.

2. Medical follow-up

Our nursing staff is aware of this, and is in the process of preparing new forms for each chart.



Your United Crusade support helps us help others

3. Lack of female staff

The next persons to be hired when funds are made available are:
a) a female counselor b) a social worker who could be female and bi-lingual c) a clerk-typist who could be female. We have been aware of this for quite some time, and because of the increase in female clients, the need becomes greater. The nursing staff and volunteers from the hospital try to take up some of the slack, but the addition of a female counselor would greatly enhance the quality of service and fulfill some of the needs of our female clients.

4. Staff training

The only training mentioned was the management training for the Director. It was not mentioned that one counselor took a two month counselling course with the City of Berkeley. Another counselor has had extensive training in psycho-drama. Two staff members are waiting to enroll in one of the training centers in Berkeley. The staff attends a few low-key educational conferences. The entire staff attended the Haight-Ashbury Conference at Mills College. Two staff members went to drug-alcohol meetings at the California Medical Association in San Francisco last year. Workshops sponsored by California Conference of Methadone Programs are also attended by the staff. In addition, we exchange our own knowledge and experiences on an ongoing basis. Because we are a small staff, whenever possible we take advantage of outside training, but our tight budget limits us to community or free training. We welcome assistance from other agencies, and/or funds earmarked for training purposes.

If our funding sources do not increase, we will not be able to continue the kind of quality treatment we like to give. There is the ever present danger that if funds are not made available, we will have to close or cut back drastically. An assistance to prevent this would be greatly appreciated.

Sincerely,

Walter Byrd
Walter Byrd
Program Director

WB: mm

cc: G. Fink
G. Passama

WEST OAKLAND HEALTH CENTER

MENTAL HEALTH DEPARTMENT

do

BOARD OF DIRECTORS

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Executive Director

Robert Cooper, M.D.

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PLEASE REPLY TO:

(X) 700 Adeline Street

Oak. 94607

835-9610

() 686 W. MacArthur Blvd.

Oak. 94608

654-0283

() 683 7th Street

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835-9610

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() 684 W. MacArthur Blvd.

Oak. 94608

653-6943

() 801 53rd Street

Oak. 94609

653-6890

() 3212 San Pablo Ave.

Oak. 94608

835-9610

Ext. 286

January 26, 1976

Matt Golden, Director
Office of Program Evaluation
Alameda County
1221 Oak Street
Oakland, California

Dear Mr. Golden:

Enclosed you will find our rebuttal to the County's Program Evaluations Unit's evaluation of the West Oakland Health Center's Methadone Maintenance Program. It is very evident that there is a wide difference in how the evaluators see our program and how we see it.

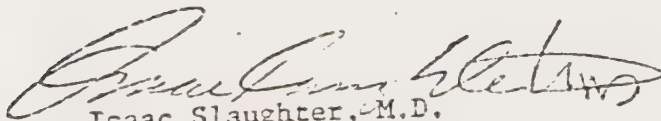
In our effort to be as objective as we possibly could, we have related mostly to those portions of the evaluation alledged to be objective.

We know that this response will not place us high on the "favored list" of the Evaluation Unit and it frightens us that this same unit is in the process of evaluating the other parts of our Mental Health Programs that we operate under contract with the County of Alameda.

We agonized about the possible vulnerability of our other programs to this unit. However, after considering all the ramifications of this, we decided to do what we had to do, and that is, to attempt to set things straight. We also felt that if they are going to be as malicious as they are in this evaluation without known provocation on our part, we have nothing to lose.

We are anxious to discuss this report further with anyone who is interested in doing so.

Sincerely,



Isaac Slaughter, M.D.
Director of Mental Health

MEMORANDUM

TO: Matt Golden, Director, Office of Program Evaluation
Alameda County
1221 Oak Street
Oakland, California

FROM: Isaac Slaughter, M.D., Medical Director, West Oakland Health Center's
Mental Health Department, Elmer Franklin, Director, Drug Abuse Services

DATE: January 26, 1976

SUBJ: West Oakland Methadone Treatment Program

Impact Evaluation Response

If this evaluation of the West Oakland Health Center's Methadone Maintenance Program were a term paper written by some college student with enough bibliography to show a reading knowledge of the subject matter, enough authoritative sounding statements and a sprinkling of "astute observations" to evidence some expertise; and enough scientific appearing graphs thrown in to add to the mystic and befuddling nature of the report, it would, as a term paper undoubtedly get an "A".

But, this is not some college student's mock and hypothetical term paper, but purports to be a very exact in depth evaluation of the WOHC's MMP. And we are not the professor to whom the paper would be given for evaluation who would be looking at the paper for content--no matter if true or false; looking for well chosen statements and process--no matter if subjective under the guise of objectivity; or looking to see if it has all the parts of a good term paper which could be determined without any knowledge of the subject matter addressed in the paper. Unlike a weary professor looking at 20 to 30 similar papers, we are the people whose program this paper purports to describe and evaluate.

We are vitally concerned about what is said and implied by this "evaluation," its' accuracies and inaccuracies, its' inclusions and omissions, its' objectivity and subjectivity and, most of all, its' conclusions. We, unlike the professor, are able to turn expert eyes on the content of the evaluation and go to the same source documents and environment to check on all the statements and inferences made in the report while at the same time professing--without any fear of contradiction--to be more familiar with the documents and more comfortable in the environment than the evaluators.

Our program has been evaluated by FDA, DEA, SONDA, and just a few months before this evaluation one of the evaluators who authored this report along with D. Levine, M.D., Director of San Francisco County's Methadone Program, serving 930 addicts, and Art Lingousky, M.D. of Alameda County's Office of Alcohol and Drug Abuse evaluated our program. They all gave our program a fairly clean bill of health. Where there were criticisms, they were for the most part fair and we have tried to use them where we could to improve our program. We have not, up until now, ever written a rebuttal to any evaluation

because they were for the most part fairly objective and not given to a lot of "Mickey Mouse" generalizations and subjective statements made as if they were the gospel truth pouring out of the mouth of an expert. The criticisms presented in this evaluation are for the most part the subjective opinions of the evaluators encumbered somewhat by those things listed in the statement in the section: Limitation of The Methodology.

"The two individuals from the drug team who were concerned with the impact evaluation were two young white women. Some of the questions asked of the clients were highly personal, intimate questions, and the responses given were undoubtedly influenced by many factors, including female interviewer-male interviewee, white interviewer-black (chicano) interviewee, drug program evaluator—drug program recipient, and a lack of the relationship over time in which trust and openness could be more fully developed. An attempt was made in all situations to be aware of these and other factors which can influence clients' responsiveness, but even so, there is no question that these factors played a part in the information gathered".

What was not said is that these two young white women were scared "shitless" the whole time they were on our program site. They saw our programs' turf as a very hostile and threatening environment to be in and got out as quickly as they could. Their state of mind is reflected somewhat in their statements in the section "Client's Comments, Section 3".

"The evaluators did not feel especially welcome in the environment and did not make as much effort to be available after hours". And their statement included under the section, "Summary of Impact of West Oakland's Program and Recommendation".

"The staff at West Oakland are faced daily with the very difficult task of trying to help persons whose problems are enormous, even if they were not addicted. The data cannot adequately describe the feeling one gets from being in the environment even for a relatively short period of time".

How can one expect an objective evaluation of a program when those doing the evaluation have such negative feelings about just coming in to it. Even when they saw something that they thought was positive about the program, they tried to explain that away, i.e.

"People who stay on the program longer are more often working, but whether that is due to the program or inherent in the clients themselves, is unknown. Since longer-term clients had the best work histories, this finding probably cannot be attributed to the program".

After being invited down to the County Building where we were given copies of our evaluation, four of the program's staff, including a Psychiatric Social Worker/Counselor, the Chief Nurse, the Program's Chief, and the Medical Director, spent two days examining the same charts in detail to discern if we could duplicate the findings of the evaluators.

Because the indictments were the most pointed in specific program areas, we will respond to those categorically. Those program areas are: (1) Inconsistent Enforcement of Rules (i.e. inadequate surveillance of Methadone ingestion, granting of take-home privileges to ineligible clients) (2) Inadequacy of counseling notes, (3) Lack of two year justification for clients receiving treatment beyond two years, and (4) Subjective statements and conclusions by the evaluation team.

Consequently, some of the conclusions we reached and pertinent information we want to point out to those reading this report are as follows:

(1) Inconsistent Enforcement of Program Rules

The evaluation team made several references to suggest West Oakland's Program rules are flagrantly violated by participants without staff taking appropriate action. Several of these comments, we feel, have little or no basis in fact.

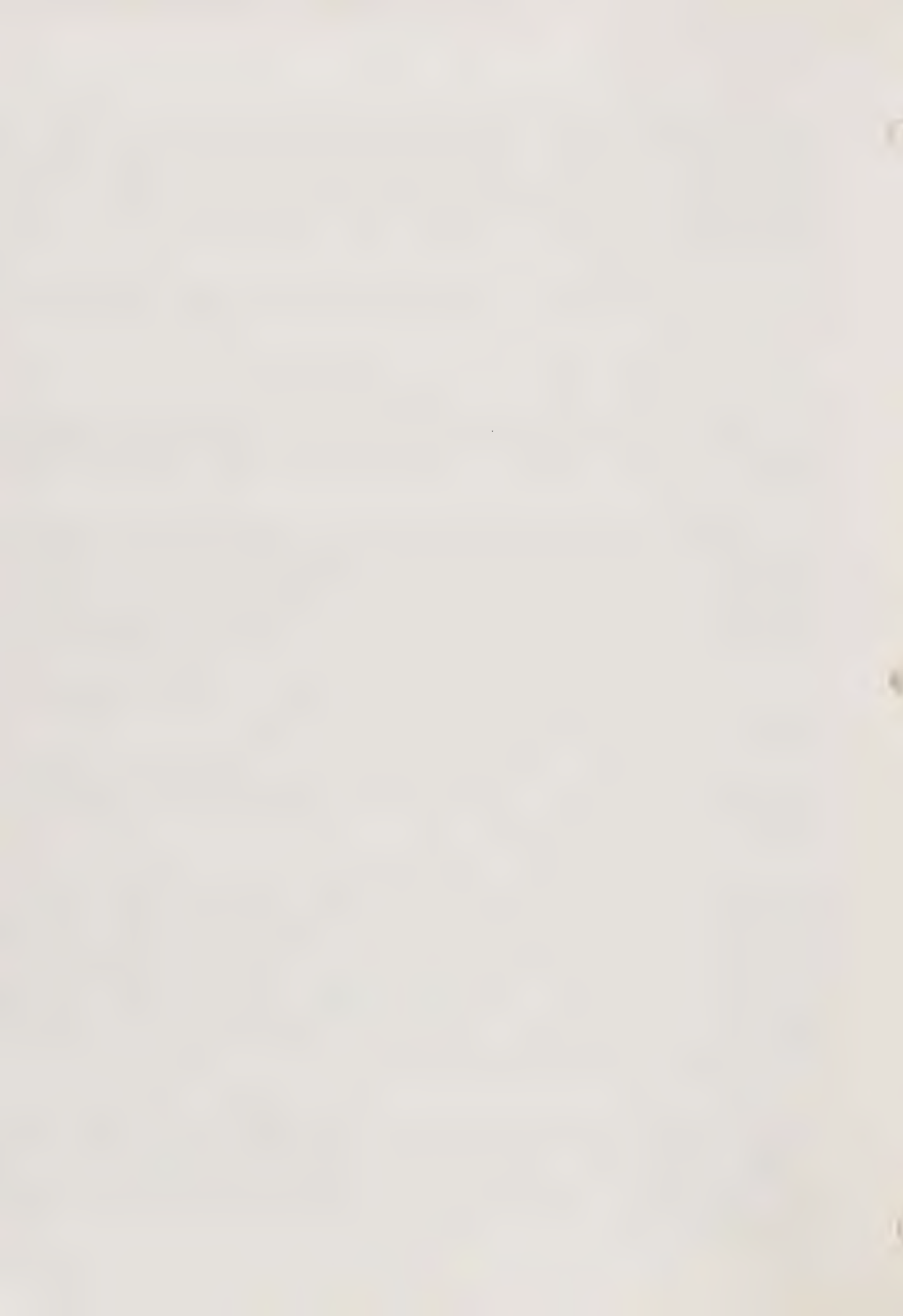
There is no accurate or consistent way to look at a group of charts written by different staff members about different participants and determine that "client's behavior is very similar while rules and regulations are used differently against them." It is more than naive to report as an objective finding and as a bonafide description of our program "this alleged different treatment" because the evaluators happened to hear a loud discourse between some staff and a participant about this "inequality of treatment".

Looking for "further clarification" promised on the first page of the report, we failed to find any. What we did find was:

(a) An erroneous statement that five times a week take-home methadone is given in our program. This is not true except in some rare emergency, or very unusual circumstance. The greatest amount of take-home legally allowable is two 2-day dosages per week.

(b) The participant's take-home history and urine results for the months of March and April, January 1974, as outlined in part 4a of the "Record Review Section: could not be found in any of the charts reviewed. Nevertheless, the evaluation team used this illustration to indicate the magnitude of alleged misapplication of program rules as related to the granting of take-home privileges. The essence of this allegation is that client #0329 urine test results indicated there was an absence of methadone or methadone metabolites on March 28, 1974, April 8, 1974, April 19, 1974, and April 29, 1974 and that each instance was proceeded by the granting of take-home privileges. Our review of this chart does not support these findings.

We are most concerned however, that the evaluation team chose to discuss the possibility of diversion of methadone in concept with the allegations of absence of methadone or methadone metabolites. Again, it appears to be obvious that the evaluation team's intentions are to lead the reader to a specific conclusion, namely the possibility of methadone diversion without taking into consideration other possibilities.



The reader of this report must be cautioned that there are several reasons for which an absence of methadone or methadone metabolite can result. Among these are (1) low doses, (2) urine is diluted from high fluid intake, (3) passing of another person's urine, and (4) not taking a methadone dose the previous day.

When we reviewed the charts we found very few instances of reports of negative metabolite while there are several reports of negative methadone. We are highly concerned about the possibility of methadone diversion and fully recognize the need to and watch diligently to insure methadone ingestion. However, we are most concerned about a lack of metabolite in the urine for it is only in this instance that one can be fairly sure methadone was not taken but even this is not conclusive. We have therefore, attached a copy of our laboratory's statement from our files to further clarify this issue.

Consequently in reference to our review of Chart 0329, we found it to be the chart of a participant who at the time was clean, working, and successfully making some positive changes in his life.

(c) The other participant described in the first paragraph on Page 5 of the report also could not be located. We did find one participant among those who's charts were screened by the evaluators, who had three weekend take-homes in October, 1975, who was on a daily dosage of methadone above 60 mg., who was arrested in October, 1975, for possession of narcotics and who had three samples reported to be positive for morphine in that same month. But here the similarity ends. For this person had been on the program 38 months rather than 23; there was no report of methadone absent in his urine in October; over the time he had been on the program he had morphine reported in his urine over 50 times, not 20, some even when he was on 90 mg. of methadone daily; he had also been in jail seven or eight times while on the program. However, for the three months prior to his being given "take-home" privileges none of his urine samples had shown a confirmed positive for morphine.

It should also be noted that this participant had been one of our most difficult participants to establish any kind of meaningful work relationship with in spite of much effort by staff. There are extensive clinical notes in his chart describing the efforts made to work with him.

Also, we found only one participant who had a large number of urines reported to be negative for methadone and metabolite. We suspected that he might have been passing phoney urines on us but each time we would try to verify this suspicion, by marking bottles and diligently observing his urinating, his urines would be negative. Because he was doing well in all other aspects of his efforts to get himself together and because he was for most of this time on doses of 35 mg. or less—which could account for this, we would relax our vigilance and the reports of urine negative for methadone and metabolite would start to show up again. He was finally caught trying to pass a phoney urine and his "take-home" privilege was suspended.

It should also be noted that we are not dealing with a bunch of Sunday School kids on this program, and for an adult to have to pee on command while being observed is sometimes difficult to do, sometimes inconvenient and time

consuming, always degrading and one helluva price to pay to keep from being sick. So, one would have to be as naive as hell not to expect that some of these efforts would not be successful.

(d) One of the rules of this program is that we try "consistently" to follow is:

"once a take-home privilege is granted, it cannot be taken away because a urine sample is reported positive for morphine unless that positive report is confirmed by the lab".

Confirmation consists of the lab running a more sensitive and morphine specific test. The time starting with the collection of a urine sample, getting the routine positive report, and getting a later confirmation report takes an average of 10 to 14 days. This might give the participant as many as two "take-home" dosages subsequent to his having given a urine sample that proved to be positive for morphine and prior to his take-home privilege being suspended. This accounted for why this participant's chart showed three confirmed morphine positive samples before his take-home privilege was suspended. Any person not familiar with this fact and while evaluating the chart noticed a confirmed morphine urine test with "take-home" doses being given subsequent to the date the urine sample was collected might very well be expected to assume that the program's staff was lax in their handling of this aspect of the program.

"Take-home" privilege is not given lightly in our program. When a participant has been on the program for three months or more, with no urines positive for non-prescription narcotics, his case is presented to the full staff at a regular bi-monthly staff meeting for consideration of his suitability for "take-home" privileges. All staff members who have had contact with him are asked for negative or positive input. After the case is discussed, a vote is taken of all staff to determine if he gets it or not. This privilege can be suspended for several reasons, the most frequent among which are:

- (1) not attending group or individual counseling—reporting on this is entrusted to his counselor,
- (2) an unexcused absence—his counselor, nurse, or program chief can grant an excuse,
- (3) attempting to pass urine sample not freshly voided by him in the clinic,
- (4) tampering with the methadone—not swallowing dose and trying to leave clinic with methadone in his mouth.

(2) Inadequacy of Counseling Notes

The West Oakland Methadone Program concedes that there are recording lapses in the social services records for some clients in the program. Nevertheless, this fact needs to be understood in the context that there has been a high rate of staff turn-over during the years compounded by not having sufficient staff (full slots) until approximately mid-July 1975. Of the

fifteen fully authorized positions, seven staff persons were hired since July 1975. Five (5) of these persons were hired in counseling positions which in essence means that prior to July 1975, the West Oakland Program had approximately five (5) counselors to service a client population of 185. This means (coverage wise) each Social Worker was responsible for thirty-seven (37) clients. As Social Workers positions became vacant, their caseloads were suspended for treatment purposes other than crisis intervention until suitable replacements were found. Our review indicates the major portion of recording gaps (2 months or more) is directly related to staff turnover. We recognized the need to take corrective action in this area and have done so by re-emphasizing the team approach for service delivery to clients. Our team consists of a Social Worker (MSW), Nurse, and Mental Health Specialist comprising a treatment team. This means when future turnover occurs among existing staff, team members will have the responsibility to continue service delivery and recording functions. Concerning the quality of counselling notes, the following excerpts were used:

July 12, 1972 "(Client's Name) came to group for the first time, _____ was disappointed because most of the members were high and acting silly. _____ voiced disapproval but got no feedback from the rest of the group".

May 24, 1973 (same record) "_____ attended group but had very little to say. Unsuccessful attempts have been made to see why _____ does not attend group".

It is obvious the two excerpts above may have been purposely quoted to suggest there is a cause and effect relationship between the entries. It just maybe, nevertheless, it could also mean other things dependent upon how the social worker viewed other aspects of this client's program participation. Nevertheless, it's of major concern that of the fifty (50) charts reviewed, the excerpts above were used as typical of West Oakland's chart recordings. While we acknowledge some of our charts are lacking in quality entries given the recorder's education, training, and background. There are excellent and extensive notes on many participants and not one word was mentioned in this regard. This is but another indication of why this excerpt appears to have been used prejudicially.

(3) Lack of Two Year Justifications

Two (2) years justifications for clients continuing on methadone is not consistently available on clients in the West Oakland Methadone Maintenance Program. Two (2) years justifications may appear on some clients in both clinical and social service records and on other clients the justification is not available. Our review of the ten (10) sample charts indicate two (2) year justifications were found in a majority of charts reviewed in this category. While two (2) year justifications may relate to the Social Worker's treatment philosophy, we fail to understand what, if anything, is inappropriate concerning this. It's implied, as indicated by the evaluator's example, Page #3, Impact Study, that the Social Worker has given up helping the client. We are again concerned about the negative inference which suggests something other than what was done needed to be done. The essence of this justification states the client cannot (or will not) abstain from heroin use and he needs to be

maintained. While one can second-guess the appropriateness of the Social Worker's decision, there is nothing wrong with it and it may, in fact, be correct in reference to this client's treatment progress. At any rate, State Regulations as required by Article 23, Section 1281, item (j) states:

"any patient continued beyond two (2) years, the circumstances justifying continued treatment must be stated".

We feel this justification meets this requirement. Moreover, we are most aware of the methadone addiction problems concerning the long-term use of methadone and this factor is given major consideration prior to our admitting an addict to our program. We see methadone as a treatment of last resort. By that, we mean we see it as a treatment for people who are chronically addicted to heroin and people who have tried other methods unsuccessfully—sometimes several times to control their addiction problem. This accounts for the validity of the evaluator's statement, "Clients have long histories of hard core drug abuse and criminal activity". The average age of people on our program is 32 and the average number of years spent in prison is about ten (10).

4. Other impressions and subjective statements by evaluation team

- a. "Criminal activity reduction is not considered to be the program's responsibility".

This statement is completely out of context, West Oakland Methadone Program's philosophy concerning criminal activity is that the reduction of such activity is first and foremost, the responsibility of Law Enforcement Agencies. Nevertheless, program staff spends much time in counseling clients to either abstain and/or not become involved in Criminal Acts. Moreover, staff is also involved in assisting clients in probation, parole, and court matters.

- b. "Since abstinence is not the goal of this program, it should not be considered the only measure of the program's success".

The above statement seriously implies the West Oakland Methadone is not concerned about clients with positive urines. This implication is grossly unfair as indicated by recordings contained in clinical and Social Service Records. Some notes clearly indicated staff confronting clients about the need to try and become clean and remain so. Granted, we have not always taken immediate and consistent action concerning positives given the circumstances of a specific client's case but we are most definitely concerned about clients making progress to become drug free. Yet, we do not arbitrarily kick persons off the program for dirties because we did not tackle the idea of treating addicts with a "Pie-In-The Sky" or "get clean or else" philosophy.

We see the problem of continuing use of heroin as an on-going treatment problem of the program and have gone through many changes in our attempt to remedy this problem. We also recognize that there are people among our clients, maybe more so than in other programs, who will probably need to continue to take methadone over a longer period of time.

c. "The State has only recently begun to require Quarterly Statistical Reporting, and it appears program staff was not adequately prepared to fill out the reports".

The overall inference concerning the quarterly statistical report to the State Department of Health is the first one we have ever had to submit, is that the evaluation team has questioned its entire credibility based upon one error concerning the number of clients tested for non-medical opiates. The reported figure was 208 and it is admittedly wrong as indicated in the evaluator's report because it does exceed the program population of 185 participants. The error resulted from a misinterpretation of the State's instructions concerning this question coupled with staff's unfamiliarity with the report and some of the data requested.

Nevertheless when the evaluators found it expedient, for whatever purposes, to use the report to collaborate or support their findings and conclusions, they did so. An illustration of this claim is evidenced by the number of persons reported in the quarterly report as attending individual counseling sessions. The number of persons receiving individual sessions averaged out to approximately one per month which was consistent with the evaluator's finding which is supported by their chart review. It has struck us as unfair and biased when the evaluator seriously questions the credibility of said report on one hand and uses same report on the other to justify its conclusions.

d. "Some staff seemed reluctant to actively encourage clients to talk with us (Evaluation Team)".

What appeared to be staff reluctance is probably more accurately related to suspicions fostered by rumors, emanating from county staff, the evaluation team was out to close West Oakland Methadone Maintenance Program. These suspicions were further compounded by a monitoring visit by the State during the evaluation. The responsibility of arranging client interviews for the evaluators was that of the program supervisor. Much time and effort was expended to accomplish this and several staff persons assisted in the coordination of these efforts. While some of these reasons were not as accessible or visible as the program supervisor, they were very much active in making telephone calls and/or trying to contact clients by other means. This kind of group indictment is wreckless and smacks of over-kill. Also, when one reviews the finished product one wonders if any cooperation was appropriate.

Summary

We did not write this rebuttal because we feel that our program does not have any shortcoming for that would be as far from the truth as we feel this evaluation is.

Before this evaluation was done, we were working to eradicate those deficiencies and we shared some of our concerns and plans with another member of the

evaluation unit's team and we find him reporting them as "great discoveries on his part as he did his exhaustive study of our program".

We are working to increase the meaningfulness of staffs contact with participants by: 1) making clearer the functional responsibility of the team to its assigned participants 2) instituting a problem related, problem solving type of progress recording, and 3) investing clearer supervisory status in the team leaders.

We are also making efforts to eradicate those legitimate deficiencies contained in the evaluation especially those relating to 1) the transmitting of Urine Dates and 2) the inclusion of two-year justification where appropriate.

IS:vc

cc: Supervisor Tom Bates
Supervisor Charles Santana
Supervisor Fred Cooper
Supervisor Don Murphy
Supervisor Joseph Bort

Members of the Ad Hoc Committee for the Evaluation of Drug Abuse

Lester, Carl - Coordinator Office Drugs and Alcohol
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O'Dell, David - Director, Alameda County Health Care Agency

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Files

M E M O R A N D U M

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Isaac Slaughter Inc
FROM: Isaac Slaughter, M.D., Medical Director, West Oakland Health Center's
Mental Health Department, Elmer Franklin, Director, Drug Abuse Services

DATE: February 20, 1976

SUBJ: West Oakland Methadone Treatment Program

Efficiency Evaluation Response

The efficiency evaluation conducted by Alameda County's Evaluation Units has generated a report that is, like the "Impact Evaluation", laden with misrepresentations, inaccuracies and subjective statements. Our reaction is to some of these misrepresentations and subjective statements that are found in the evaluation especially in the sections entitled, "Organizational Structure", "Management", Counseling Productivity", and "Financial Management".

On Page 3, Section: "Organizational Structure":

The evaluator's statement: "Although The Board of Directors of the Health Center is responsible for the Methadone Program, the organizational chart does not fix responsibilities within the Methadone Program".

is very unclear. Our Board is a policy making board while the responsibility for the day to day functioning of the center and its programs is vested in the Executive Director and the various department heads.

In this same section his statement:

"evidence was present that friction exists between Health Center and Methadone personnel."

is ludicrous. Why not cite the evidence if it was present? The Medical Director of the Methadone Program is one of the Department Head and senior staff of the West Oakland Health Center and as such has some input into the day to day operation of the entire center. This obligates his involvement in the development and implementation of personnel and fiscal policies of the West Oakland Health Center and these policies once promulgated affect all center employees alike.

Page 3, Section: "Management":

The evaluator has reported that he, "observed nurses responding to clients in arbitrary ways over dispensing of Methadone. It further appeared that some nurses utilized the periodic urine tests as a punitive measure toward clients not conforming to their expectations".

When the nursing staff was questioned concerning this allegation, it was denied, and especially so since the "Observation" provided to support this allegation is a misrepresentation of what actually transpired.

The event in question and what actually happened is as indicated below:

1. A program participant did in fact report to the clinic prior to the close of dispensing hours and could not void until approximately 15 minutes after the 2:00 p.m. deadline.
2. The dispensing nurse initially told the participant she would not receive her medication because this particular participant had been habitually tardy and sometimes absent.
3. The participant then sought out her counselor (Social Worker) to intercede in her behalf. (The participant was loud and made several references to staff having "favorites" among other participants).
4. The Social Worker tried to intercede in the participant's behalf, but the nurse refused and the Social Worker informed the Program Supervisor of the problem.
5. The problem was discussed between the Program Supervisor and dispensing nurse and it was jointly agreed the participant would receive medication but would have to void more frequently because of prior absences and/or tardiness.
6. The participant refused medication because of this condition and made several threats to expose alleged "favorites" to the Medical Director.

The above situation appears to be a clear example of staff complying with program policy while trying to deal with a delicate situation in the client's best interest. The fact of the matter is this participant knew damn well evaluators were on site and tried to use this situation to draw attention to her plight. She successfully accomplished this, and she hoped this would be sufficient to cause program staff to capitulate to her demand, namely, receiving her medication without voiding and loudly alleging other program participants had been given the same privilege while she was being denied.

We call this "gaming" or more appropriately, "bullshit". The incident couldn't have been staged better. If the evaluators were not on site, chances are this client would not have used this particular ploy, but rather some other she hoped would have been equally effective.

While we don't intend to make this response a social and ethnic discourse, we have provided this detailed explanation simply because of the hidden cultural factors surrounding this incident. Most participants at West Oakland are Black and have been adversely affected by discrimination and poverty, police and judges, and ultimately jails and prisons. Moreover, most clients lives are dependent upon welfare or some other derivative of social legislation. Consequently, most of our clients have learned, and sometimes regrettably so, to

manipulate any or all these institutions for their benefit.

Our staff understands and recognize all of these cultural "games" which a life or racism and its concomitant factors have forced on most of our clients. Our clients are not easy ... and incidentally, this program does not accept or reject applicants on this basis. In fact, we have numerous participants we suspect have been labled as rejects or undesirables by other programs within the community, perhaps due to the inability of some potential clients to readily conform to middle-class values. Remember, it's those clients' inability to conform to society's rules which, in part, are responsible for their lack of success with the system in the first place.

What concerns us most, however, is the manner in which the evaluator used his observations to infer that urine testing is used as a punitive tool at West Oakland. The second observation, also on Page #4, asserts that the dispensing nurse said she would "fix the guy" concerning some conflict at the dispensing counter. This observation is somewhat confused by the evaluator since the only incident concerning voiding for several days occurred in the instance already described. Nevertheless, the allegation concerning a nurse saying she would "fix the guy", which all nurses disclaimed, needs to be examined in view of its negative ramifications.

Needless to say, this is the kind of allegation which can easily be denied, even if true, and we have no reason to challenge the evaluator's integrity concerning his report of the incident, excepting that which is already stated concerning voiding. What we do challenge nevertheless is the evaluators perception and understanding in reference to the addict peculiar to our population, and most importantly, his inference that something unnecessarily punitive is occurring with our urine collection.

We don't apologize for making occasional "tough" statements nor taking "tough" actions as long as such actions don't violate federal or state regulations pursuant to the administration of methadone programs. Talking "tough" at West Oakland is sometimes the last resort to get one's point across, the emphasis being to inflect seriousness and sometimes get through "gaming" and/or bullshit.

Concerning the organizational structure at West Oakland Health Center with specific reference to the dual authority as vested in the Chief Nurse, and Program Supervisor, we have been working for months on a different management model (see attached). This model was discussed with the evaluator during its developmental stages and prior to revealing it to staff. Yet, the evaluator made several references to this quality of responsibility without revealing any indication that plans were being developed to remedy the situation. The management model attached went into effect on February 9, 1976 after numerous discussions with staff concerning all aspects of its adaptability and implementation. Also, new and improved job descriptions and functions were developed as a part of this process.

It should be re-emphasized that these changes were in the making many months before this evaluation was made. Also, some of these changes were discussed with the evaluator while he was here. So, it is somewhat disconcerting to see the discussed changes appear in his report as program defects and as recommendations as if these were his personal findings and conclusions after having a long "indepth" look at our program.

This information is offered as proof that we are and have been vitally concerned about making whatever improvements necessary to do a better job in our clients and agency's best interest. We would hope these efforts are always given similar recognition by evaluators as apparent or alledge weaknesses have been given.

Another example of subjective reporting concerns the evaluator's observation in reference to clients drinking on the clinic premises. The unmistakable inference by the evaluator is that staff does not enforce clinic rules concerning the prohibition against drinking on clinic property. The evaluator wrecklessly concluded the following as it pertains to this situation:

"However, fear of physical reprisals by clients was offered as the reason for nonenforcement of this policy. It appears that the nursing personnel have clearly demonstrated they are incapable of accepting certain responsibility and authority for certain program policies."

Firstly, it's the responsibility of all program staff to deal with any violation by participants on clinic premises. This function is not limited to nurses, but because of their prominent location within the clinic, they are sometimes the first to observe and deal with rule infractions. If and when there are physical threats, these are almost always verbal and these incidents are usually quickly quieted with or without male staff intervention. While staff recognizes the possibility of actual physical violence, this has not interfered with staff's ability to enforce any agency rules, and especially the one concerning drinking.

We have tried to eliminate drinking and we accept the fact that it requires consistent and daily monitoring which is being done. We have also made several alcohol treatment referrals to various treatment facilities within Alameda. Moreover, it's a repeated theme in working with clients individually and in groups. We are also initiating an Alcohol Detox Group as a part of our reorganization to deal with this problem. This group will be run by Dr. George Taylor, who is now the clinic physician.

Consequently, the statement alledging nurses incapability to enforce certain clinic rules is totally without merit. It's a random and isolated statement concerning a specific situation which has been used to suggest that nurses are ineffectual and/or afraid of participants.

Concerning statements in reference to counseling Productivity, the evaluator quoted a figure of 23% as an approximate of the amount of time West Oakland counselors spend delivering counseling services. We know that this figure is low, but it is consistent with the reported figures contained in our Quarterly Report ending September 30, 1975. In effort to more accurately account for the number of individual and group counseling sessions held. Our reorganization of the Methadone Program is requiring accurate documentation of all such sessions and a monthly report to be submitted to the Program Director. These reports will subsequently be monitored by the Program Director against actual chart recordings and treatment plans of each client.

On page 6, under the section: "Financial Management":

"The financial records for the methadone program are maintained by the accounting department of the West Oakland Health Center. The service

provided seems to be adequate, however, there are some problems over contract interpretation. Recently, the methadone program failed to receive prior written approval from the County or the State for the transfer of funds from one budgetary category to another. As a result, there was approximately a \$4,000 disallowance for certain expenditures. This situation has created conflict between the methadone program and the Health Center."

This entire section is as mixed up as one can get, but is another example of the shallowness of this "indepth evaluation". It is another example of the evaluator hearing a fragment of a conversation, grossly misinterpreting it and placing it in his report as an evident weak point of our program.

Errors:

1. There has been no \$4,000 disallowance. This program's budget has not even been audited. We are trying to prevent a disallowance.
2. There is no problem with contract interpretation. We are well aware of what our contract says and means.
3. There is no conflict between methadone program and the health center about this matter.

The facts of this matter are that, when the 1974-75 budget was made the projected expenditure for urinalysis cost was inadequate. The reasons for this are that,

1. There was an increase in the cost for urine test.
2. There was an increase in the number of urine test required by the program over that period.

These two factors caused an overrun in that budget item. The West Oakland Health Center's Fiscal Department, because it does its job well, noticed this developing overrun and called it to the attention of the methadone program staff, the Medical Director then made this known to the County and State Drug Office. We requested the State to lift some budgetary restraints they have placed on drug program which we feel are grossly unfair. This restraint prevents the transfer of more than \$1,000 from any line item to another in the budget. This is unfair to us because:

1. The budget overrun was caused by us expending money to pay for a State and federally mandated service over which the program has no control. That is, we have to do a certain number of urine test on each of the participants in the program if we want to continue to operate a methadone program.
2. We have no control over the unit cost for these test. The state approved lab set the fee.
3. We are not requesting the state to increase the cost of the program. We are only asking to be allowed to use monies saved in other budget categories to defray this overrun. Because of the

above reasons, we feel that this is a valid request and are still negotiating with the state's drug office concerning this change. Again it should be emphasized that this problem has nothing to do with the Fiscal Department of the West Oakland Health Center except as stated above and certainly has not "created any conflict between the methadone program and the Health Center."

In conclusion, we want to emphasize that we recognize we have program weaknesses and on-going actions are being taken to rectify these. As indicated in this report, several actions had been started prior to beginning this evaluation. While we recognize we have some program deficiencies, we are discouraged and concerned with the overwhelming conclusions in both reports (Impact and Efficiency) were negative. There was very little in either report to suggest to us the evaluation team understood the myriads of social problems, specifically the lack of jobs, education, vocational and job training, substandard housing, and a higher than average crime rate, contribute to an early introduction to drug abuse. While we do not want these factors to obscure objective program deficiencies, we do believe these must be taken into consideration in any proposed in-depth evaluation of our program. This is all the more reason why any independent observations, in any evaluation, must be carefully checked prior to submission as facts if one is concerned about both fairness and objectivity. We had hoped this would be the case, but hardly think so, based upon our analysis of the evaluator's findings and conclusions.

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